

SERIAL HANDBOOK OF MODERN PSYCHIATRY • VOL. II

# Psychiatric Syndromes and Modes of Therapy

JULES H. MASSERMAN, M.D.

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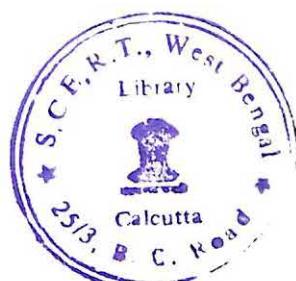
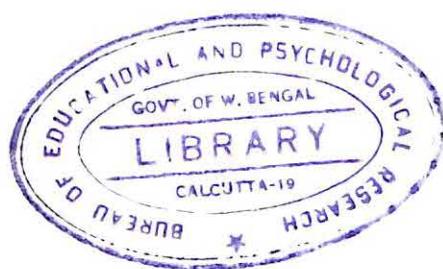
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# Psychiatric Syndromes and Modes of Therapy

With a Glossary of Clinical Definitions of Terms

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Stratton Intercontinental Medical Book Corporation  
New York

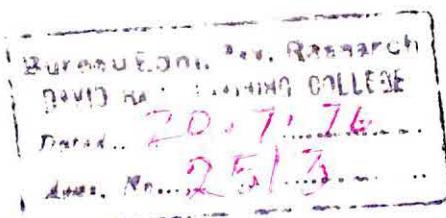
Copyright © 1974  
Stratton Intercontinental Medical Book Corp.  
381 Park Avenue South  
New York, N. Y. 10016

LC 73-23017. ISBN 0-913258-17-2  
Printed in U.S.A.

S.C.E R.T., West Bengal

Date 20.7.76

Acc. No. 2513



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## PREFACE

The term "diagnosis" is a direct derivative from the Greek *diagignoskein*, which literally means *discriminating* and *separate knowledge*. When properly applied to all branches of medicine, including psychiatry, the term *connotes a thorough understanding of an individual patient as distinguished from all others*, as opposed to a Procrustean relegation to iatropoietic categories.

This truism posed a dilemma to the organization of this book. On the one hand, the psychiatric student and resident, through routine texts and lecture series appropriately fragmented to conform with a currently official Diagnostic Manual, is taught to impound his patients within atavistic enclosures miscalled mental diseases. On the other hand, as he gains clinical experience and wisdom, he must recognize that the nosologies he was taught have almost no etiologic, phenomenologic, pragmatic or therapeutic significance other than to accumulate misleading statistics. Instead, he finds that every person has almost every mode of behavior available, and that whether the various adaptive or maladaptive patterns he utilizes at a given time are labeled either "normal" or, pejoratively, "neurotic," "sociopathic," "borderline" or "psychotic" depends in large part on whether or not the patient's conduct is compatible with the therapist's concept of time, place and social order.

For the sake of current compatibility, the chapter and section headings in this treatise will follow the Second (1968) Revision of the Diagnostic and Statistical Manual of Behavior Disorders; however, the fifty case histories, although coded by DSM II, will cite all of the intricate genetic, experiential, ethnic, cultural and other interacting vectors relevant to the etiology, symptomatology and prognosis in every unique instance. So also the versatile rationale and comprehensive modes of therapy described transcend current nosologic boundaries.

An appended glossary and name and subject indices will, it is hoped, further commend this volume to all who deal empathetically and helpfully with human relationships and vicissitudes.

*Jules H. Masserman, M.D.*

Know then thyself, presume not God to scan;  
The proper study of mankind is Man. . . .  
Sole judge of truth, in endless error hurl'd  
The glory, jest, and riddle of the world

From "*An Essay on Man*," by Alexander Pope

## Chapter 1

### CLINICAL SYNDROMES IN PSYCHIATRIC DIAGNOSIS

It is a common complaint that the current system of psychiatric classification outlined in the Second Edition of the Diagnostic and Statistical Manual adopted by the American Psychiatric Association in 1968 employs terms which have long since lost their original connotations and that now have little reference to the etiology, nature, phenomenology, prognosis or therapy of the behavior disorders to which they are applied. It may even be objected that the derivatives of the root term *psyche* have reference to a quasi-mystic abstraction which can be diseased ("psychopathology"), can be melted down ("psychoanalyzed") or healed by subservient treatment (psychotherapy; Greek *theraps* = servant). Conversely, the term *neurosis*, though now applied to "general affective dysfunctions" (Cullen, 1769), specifically defined as not attributable to gross organic changes in the nervous system, stems from historical concepts that neuroses *were* caused by sejunc- tions or diaschises (von Monakow) in the neuronal pathways. Still unwilling to deny the possibility of such neuropathologic changes, Freud, too, in his early writings, distinguished the *actual* (Feuchterleben, Wernicke) *neuroses* (e.g., neurasthenia, which he attributed to the adverse physiologic effects of masturbation) from the *psychoneuroses*, which had a purely psychologic causation—a distinction which has nearly everywhere been abandoned. Even more anachronistic are other terms used for the various "types" of neuroses, e.g., hysteria, so-called from the Hippocratic theory that the disorder was caused by a wandering uterus (*hysterus*) which, when it caught in the throat, was sensed as *globus hystericus*. On this basis, indeed, hysteria was regarded as an exclusively feminine affliction until Greisinger, Charcot Janet, *et al.* demonstrated, against the usual *a priori* disbelief, that "hysterical" disorders also occurred in male patients presumably immune to uterine wanderlust.

Even apart from the derivations of such terms, the rigid systematization of mutually exclusive diagnoses in current tables of psychiatric classification gives a false impression that they actually deal with independent disease entities. Unfortunately, the student of psychiatry, however accustomed he may have come to delight in the puristic fitness of most scientific terminology, must instead learn to use a vocabulary about as inap-

plicable to a dynamic study of behavior as the Ionic terms, air, fire, earth and water, would be to a modern study of nuclear physics.

Numerous previous attempts had been made to remove these semantic confusions and thereby facilitate research and therapy. One obvious possibility was to set up an entirely new terminology based on the comprehensive etiologic, dynamic, prognostic and therapeutically accessible aspects of behavior rather than on classifications of its protean, infinitely variable manifestations. Adolf Meyer attempted to do this in his system of "ergasiology" in which the "indissoluble psychobiology" of the whole individual was studied from a constitutional, developmental and adaptive as well as a merely phenomenologic standpoint. Kubie, Soule, Dunbar, Rado, Walter Menninger and others proposed other terminologic systems, each of which had its special merits. And yet experience has shown that such efforts have succeeded only slowly, if at all, and that psychiatrists have continued to cling to terms which, to use another simile, have as little relevance to the subject matter of psychiatry as do the mythical names of the stellar constellations to astronomical physics. Nevertheless, this conservatism persists and, like other cultural phenomena, is not amenable to drastic or unilateral changes. The clinical classifications used in this book therefore remain in conformity with the official DSM.\* However, in accordance with modern biodynamic orientations, this terminology should be employed with the following implicit provisos:

1. That the "diagnostic" terms used refer roughly to predominant modes of behavior and not to disease entities. (See Glossary.)
2. That even the larger categories of disorder as well as the sub-groups differ from "normal" only in the degree, persistence and relative unadaptability of the "aberrant" patterns with relation to the patient's current or prospective milieu.
3. That any diagnosis can be only relatively "differential" and never exclusive, since nearly every known pattern of "normal" or "abnormal" behavior is operative to a greater or lesser degree in every subject. Rather, psychiatric "diagnosis" (Greek: thorough understanding) consists in a

\* Parenthetically, the Latin derivative *mens* (as in *mental*) is dynamically preferable to the ethereal Greek *psyche* (as in *psychiatric disorders*) provided that, in accordance with modern systems-interactive concepts, the English derivative *mind* be regarded as a *verb* (denoting *process*) rather than as an essentially undefinable *substantive* or *noun*. In this sense, the mentally retarded or organically handicapped patient cannot "mind" (sense, perceive, conceive) his surroundings or, in mnemonic defects, "remind" himself of significant past experiences (those which did not pierce through). In contrast, "neurotics" and "psychotics" distort, in various socially deviant degrees, and thereby do not "mind (accept, obey, adapt to) their social order, with various prognostic and therapeutic considerations.

recognition and weighing of the *predominant* deviations of behavior, with full allowance for other reactions, even though present to a minor degree. In this sense, although all "neuroses" and "psychoses" are mixed, the relative prominence of a few patterns may justify a clinically meaningful designation.

4. Similarly, prognosis is not an inevitable consequence of any classificatory label, since nearly all behavior tendencies are reversible to a greater or less extent; indeed, many acute "psychotic" reactions are more readily amenable than some labeled "neurotic." Prognosis, therefore, depends on an evaluation of the origin, tenacity and influenceability of the patient's behavior tendencies and on the possibility of channelizing them into new and more favorable adaptations by available therapeutic means.

No efforts to describe exhaustively all possible semiotic combinations, therefore, can or need be made, and it is with this proviso that the following descriptions and case illustrations are presented, beginning with the problems most frequently encountered and proceeding to the more manifestly deviant syndromes. The observer, unprejudiced by rigid nosologies and instead prepared to comprehend what he sees, hears and elicits, will then expand his clinical perceptions and round out his diagnostic acumen.

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## Chapter 2

### PERSONALITY DISORDERS

The diagnosis of *personality disorder* (DSM, II, Section 5) is, perhaps more than any other, likely to be a subjective and cultural judgment of a person's behavior phrased in such subtly pejorative psychiatric terms as "passive-aggressive," "inadequate," paranoid, etc. Indeed, the implicit connotation of *sociopathic personality* is still "any patient whom most people—and especially I—don't like, can't treat, and can't commit." More objectively these are *persons who, instead of developing specific symptoms such as phobias or psychophysiologic dysfunctions*, manifest their conflicts in repetitive familial, sexual, occupational and other social maladaptations. Franz Alexander has drawn a parallel distinction between the internalized *autoplasic* reactions of the hysterical or compulsive patient on the one hand, and the *alloplastic* or externally directed activities of the sociopathic personality on the other. Such differentiations, then, attempt to distinguish "personality disorders" from the following (see Glossary):

1. "Normal behavior," in which, of course, the subject also "acts out" his motivations and adaptive patterns, but in a more interpersonally and socially compatible manner—or at least sufficiently so that the subject neither wishes psychiatric help nor comes into major conflicts with his social order.

2. *The psychosomatic disorders*, in which the symptomatic aberrations are primarily sensorimotor or organic.

3. *The phobic-obsessive-compulsive neuroses*, in which aberrant total behavior is obviously involved, but in more limited and circumscribed fashion; i.e., symbolic thoughts, aversions or compulsions aroused only under specific circumstances.

4. *The borderline personality*, a classification proposed by R. Grinker, Arlene Wolberg and others on the implied assumption, difficult to maintain clinically, that there are definite "borders" to the diagnostic categories listed above and below.

5. *Criminality*, in which the patient consciously acts against the social order and, presumably, has little or no conflict over his conduct and only subliminal incentives to change it.

6. *The psychoses*, in which behavior becomes more dereistically fantasy-ridden, sweepingly disorganized or markedly regressive.

**TYPES OF PERSONALITY DISORDERS (DSM II, 301)**

The term "personality" has an interesting derivation from the Latin *persona*, the mask through which an actor speaks. Etymologically, then, "personality" connotes not the real individuality of the actor, but the external appearance he assumes and the roles he rehearses and plays. The following pseudo-descriptive terms are used:

*Constitutional inferiority.* This connotes a presumption that the patient's difficulties in behavior are due to congenital defects or an inferiority of physical makeup established so early in life as to justify the term "constitutional." The term might be applicable to the congenitally retarded (cf. DMS II, Section 3) or, in a far less exact sense, for those rare patients who, though not intellectually defective, seemed from their earliest days incapable of developing self-control or social responsibility—a category first called by Prichard *moral insanity*. As noted, the current term, "sociopathic personality" (v.i.), if loosely used, is less indicative of the nature or etiology of the behavior disorder than of an attitude of superiority over, and rejection of, the cultural environment.

*Inadequate personality.* This has fewer organic connotations than "constitutional inferiority" but is scarcely more meaningful from an operational standpoint. It is generally applied to individuals who, even though they are relatively content and well accepted in their own milieu, have not achieved a degree of familial, educational, sexual, social or occupational success considered "adequate" in a different culture. As may be anticipated, "inadequate personality" has often been used glibly and sometimes with not altogether unconscious smugness to describe the harmless vagabond, the untroubled bohemian, the impoverished, the unproductive but happy minor artist and other such folk not too concerned about either the opinions or the officiousness of the social order, and who manage to remain relatively serene—to some observers annoyingly so—in their chosen role. More objectively employed, the term has some usefulness in denoting patients who fail to achieve successes prescribed for them because of motivational or other adaptational deficiencies; even in this connection, however, it must be remembered that, if the standards were to be revised, their "psychiatric difficulties" would disappear.

*Infantile* and *puerile* personality are terms describing behavior difficulties parallel to those mentioned and ascribed to "emotional immaturity" in adult individuals who have remained fixed at, or have consistently regressed to, the narcissistic, dependent and aggressive patterns of childhood.

*Sociopathic (formerly "psychopathic") personality.* This term is applied to a person, otherwise classifiable in the above categories, who has in addition developed behavior patterns which conflict seriously with the

social mores and, potentially or actually, with pedagogic, clerical, police, or other regulatory authorities. In this group would fall sexual exhibitionists, inverters or perverts, kleptomaniacs, pyromaniacs or other compulsively destructive individuals, alcoholics and drug addicts, and patients with patterns of neglectful, irresponsible, or overtly hostile behavior leading to serious consequences for themselves, their homes, their families and their business or other associates. Obviously, in such cases the differentiation from "pure" criminality would theoretically lie in the sociopath's recurrent (though superficial and transient) conflicts over his behavior, in his recurrent professions of regret and in his transiently sincere desire for psychiatric or other help in altering his conduct. Actually, however, the differential criteria of inner conflict, external "intent" and partially maintained social "rapport" are complexly determined and difficult to fix on either legal or psychiatric grounds.

For example, is a mother with intensely ambivalent feelings about her children to be judged more "criminally neglectful" if she escapes from her conflict by "sociopathic" alcoholism and extramarital affairs, or if she harms her offspring much more by neurotically excessive but socially tolerated overindulgence or rigid discipline? Or again, is a husband more entitled to a divorce if his wife is physically abusive to him and neglectful of his home, or less so if, while observing every appearance of social amenity, she makes his private life unbearable by covert depreciation, sexual frigidity, "unthinking" extravagance, and other subtle but excruciating hurts and frustrations? Such questions raise juristic as well as psychiatric problems that cannot be scientifically resolved by arbitrary classifications which do not correspond with the complex multidimensionality of human conduct.

We must infer that the distinctions between "neuroses" and personality disorders and among the various "types" of neurotic character are far from definitive since, as will be seen, all forms of neurotic behavior (a) shade off from "normal" only by virtue of teleologic and social gradations; (b) are inevitably accompanied by some degree of internal conflict and anxiety; (c) always involve the "total personality" no matter how prominent certain "psychosomatic" or other special manifestations may be; (d) necessarily have concealed asocial or antisocial incentives or "intent," whether primary or secondary, and finally, (e) are expressive of fantasy formations which are distinguishable from those in psychoses only by the circumstances that in the neuroses the socially compatible compromises and adaptations have not broken down to as great an extent.\* In

\* In an earlier treatise, *Current Problems in Psychiatric Diagnosis* (Hoch and Zubin, Editors, Grune & Stratton, 1953), O. Diethelm has a chapter on "The Fallacy of the Concept: Neurosis." T. Rennie advocates the abolition of the term *psychosis*, and M. Guttmacher, an authority on forensic psychiatry, states that "at present, the diagnosis of a *Psychopathic personality* is practically meaningless."

the diagnosis and therapy of the character neuroses—as elsewhere in dynamic psychiatry—it is therefore evident that quantitative, qualitative and dynamic formulations will be found more useful than the prejudicial, legalistic or social judgments implied by our current nosology.

### "TYPOLOGY" OF BEHAVIOR

Homer and Sophocles portrayed with consummate skill the infinite varieties of human experience that also illumine the plays of Shakespeare, the novelettes of Voltaire, or the pages of Strindberg and Hemingway. They described no automatons performing with mechanical precision according to some prescribed "type"; on the contrary, all *dramatis personae*, real or fancied, were seen to be too richly complex for such hollow, predictable puppetry. And yet when self-professed savants sought to clarify man's conduct, they began to slight its dynamic depths and infinite subtleties in a vain search for a simple typology that would create, by force of edict if necessary, some semblance of order in their studies. This approach was first given a certain philosophic dignity by Theophrastus, Aristotle's successor at the Lyceum of Athens, and, as traceable through Galen in early medicine, Jean La Bruyere (1645-96) and the French characterologists, to Allport and other more modern "trait" psychologists to Kraepelin in psychiatry, typology still channels some phenomenologic and nosologic thinking. A typical instance of such unidimensional "character analysis" may be quoted from Theophrastus himself:

CASE 1. *The Penurious Man*—by Theophrastus. A Penurious Man is one who goes to a debtor to ask for his half-obol interest before the end of the month. At a dinner where expenses are shared he counts the number of cups each person drinks, and he makes a smaller libation to Artemis than anyone. If someone has made a good bargain on his account and presents him with the bill he says it is too much. When his servant breaks a pot or a plate, he deducts the value from his food. If his wife drops a copper, he moves furniture, beds, chests and hunts in the curtains. If he has something to sell he puts such a price on it that the buyer has no profit. He forbids anyone to pick a fig in his garden, to walk on his land, to pick up an olive or a date. Every day he goes to see that the boundary marks of his property have not been moved. He will dun a debtor and exact compound interest. When he entertains the members of his deme, he is careful to serve very small pieces of meat to them. If he goes marketing, he returns without having bought anything. He forbids his wife to lend anything—neither salt nor lamp-wick nor cinnamon nor majoram nor meals nor garlands nor cakes for sacrifices. "All these trifles," he says, "mount up in a year." To sum up, the coffers of the penurious man are moldy and the keys rust; they wear cloaks which hardly reach the thigh; a very little oil-bottle supplies them

for anointing; they have hair cut short and do not put on their shoes until midday; and when they take their cloak to the fuller they urge him to use plenty of earth so that it will not be spotted so soon.

It is evident that in this interesting literary portrait Theophrastus skillfully elaborates the various expressions of a single "personality trait"—penuriousness—and, indeed, describes behavior patterns recognizable in certain guardians of academic and research purse-strings today. It is equally obvious, however, that in order to preserve this simple autochthonous approach, Theophrastus makes no attempt to canvass the total character of the "penurious man": his taste in music, his bravery in battle, his religious beliefs, his skill and delight in throwing a javelin, his sexual preferences or his devotion to his country or his children. And if Theophrastus or his modern disciples were to postulate that special proclivities in these and other fields of human conduct are also to be subsumed under the headings of separate "traits," there still remain the highly important considerations as to the interrelationships of these patterns, their common or multiple dynamic sources, and the circumstances that influence their single or joint expression. In this connection, too, the subjective and social aspects of all "trait" evaluations make their troublesome appearance. For example, it is perhaps significant that none of Theophrastus' thirty classic sketches of various "types" of Athenian character is particularly complimentary to its subject; indeed, despite his assumed scientific detachment, Theophrastus, like his modern counterparts, seems to have regarded his fellow citizens with a cynical, if not a pronouncedly jaundiced eye. And yet the man Theophrastus, with some moderation, called "penurious" would have been praised by his grateful creditors or heirs as "foresighted" and "thrifty," or, conversely, more severely denounced as "miserly" or "heartless" by disappointed aspirants for his benefactions. Moreover, scientific questions of even greater importance arise with regard to the origin, dynamisms and influenceability of the man's behavior. Why did the man become penurious in the first place? Was it "caused" by his genes, his early or later experiences, his intercurrent illnesses, or all three and much more? With a given etiologic configuration, under what circumstances is he likely to be more or less penurious? And, if his miserliness has become a burden to himself, his family or his society, what, from a pragmatic standpoint, can be done to change him to a way of life more satisfactory to all concerned?

Questions such as these long ago probed the biases, inadequacies, and sterilities of the exclusively descriptive and classificatory approaches to the study of character, and made the development of a dynamic psychology of behavior scientifically necessary. The following case histories may serve as current clinical illustrations:

**CASE 2.** *Antisocial (borderline) personality (DSM II 301.7) with alcoholism and neurasthenic neuroses (300.5).* A 22-year-old youth applied to the gastrointestinal and genitourinary clinic for relief of anorexia, weight loss, dysuria and dull back pains. Since all physical findings were normal and he failed to improve under dietary regulations and medical therapy, he was referred for psychiatric study. The following history (with minor alterations to conceal identity) is transcribed from his record (see Vol. I of this series for interview techniques):

*Complaints.* The patient recapitulated the symptoms of which he had complained in the medical clinics and stated that he had been in no way benefited by medication and diet. He added that he had also experienced general feelings of inferiority and insecurity since childhood and had suffered sexual impotence during the past three years. In the latter period he had become increasingly alcoholic and now imbibed a pint to a quart of hard liquor daily.

*Summary of Past History.* The patient volunteered that throughout his childhood he was excessively pampered and indulged by his well-to-do parents and by his two elder sisters. Since he had become accustomed to such treatment at home, he found it difficult to curb his demands and temper at school and elsewhere despite the fact that, in retrospect, his behavior made him increasingly disliked and insecure. Because of his high intelligence he could make good grades with little study, and did so mainly to counterbalance feelings of inferiority and isolation in other respects. Nevertheless, he left high school at 17 because he had "felt friendless, and besides, my folks didn't say I had to keep going." Supported by his family, he then remained idle for a year "looking for something I might like to do." At the end of this time he was involved in a minor street accident which, though he was uninjured, netted him a windfall of some two thousand dollars in settlement of his claims. The patient ostentatiously spent this on a limited group of adolescents and so attracted a coterie of acquaintances whose "friendship" he tried to keep by drinking and joining in various borderline delinquent escapades. At the time of his hospital admission the fund had become about exhausted and the patient, though he felt totally unequipped in either ability or temperament to settle down, was finally being pressured by his family to go to work.

*Sexual Development.* The patient claimed that he had been erotically stimulated by his sisters in early life, and remembered variable feelings of guilt over incestuous masturbation fantasies. During the past two years he had been having sexual relations with a friend of his sisters, but he was generally impotent "unless I'm pretty drunk and don't think what I'm doing." Moreover, he had become increasingly uneasy because the girl wished to marry him, whereas on his part he didn't "feel ready to tie myself down and support anyone else."

*Mental Status.* The patient was neatly groomed, and initially polite and prepossessing in manner. His intelligence, as judged by his cultural background, memory, accuracy of perception, abstraction and integration, imagery, speed of reaction and logical accuracy, was rated as above average (a later Stanford-Binet test was graded 128). His attitude, however, was characteristic; in practically all fields of discussion he began with apparently frank self-depreciation and contriteness, proceeded to self-pity and sympathy-seeking, appeals for "understanding" and "help," and ended with self-justifications and hostile projections of

blame on his parents, who "spoiled" him, his drinking companions, who "dragged me down," his fiancée, who "wants to corral me," etc. In mood, he was somewhat depressed and slightly anxious, but more in relation to his diminishing funds and the growing impatience of his family and fiancée than over his own failures and incompetence. Similarly, there was little anxiety over his physical condition and even less with respect to his impotence; on the contrary, the patient seemed actually to cherish the latter as a possible reason why his girl might relinquish her desire to marry him. He was quite willing to attribute all of his complaints to his "nervous state" but loath to admit, let alone analyze further, the personal and social difficulties arising out of his own dependence, indolence and alcoholism.

*Course Under Therapy.* A fair working rapport was cultivated with the patient by taking advantage of his desire to unburden himself and his professed need for guidance out of his current dilemmas. His immediate anxiety was relieved and his confidence and gratitude were increased when the psychiatrist, in an interview with the patient's fiancée, led her to see that it would be to her own advantage to postpone her current plans to marry the patient "so as to make a man of him," an "active interference" on the part of the therapist for which everyone concerned was ultimately grateful. The therapist next encouraged the family to induce the patient to take an available job as a bank clerk; since the parents covertly delighted in their only son's continued dependence on them, this move had to be formulated in such a way that neither they nor the patient would consider it a radical step toward emancipation. Nevertheless, the patient, in bimonthly therapeutic interviews, was held at his work despite expected resistances and anxieties and gradually began to enjoy the feeling of being needed and paid by people other than his family. He also began to join his fellow employees in their bank picnics, clubs and group athletics, and so lost more of his feelings of social isolation. His alcoholism abated and his health and conduct improved so steadily for several months that our previously guarded prognostications seemed unnecessarily gloomy.

Then, as frequently occurs in such cases, a "minor" stress once again precipitated a chain of reactions with major consequences. Specifically, his fiancée began to renew her proposals that, in view of his recovery, they should now get married. Under this pressure, the patient's work at the bank again became less satisfying to him, he lost interest in emancipatory extrafamilial relationships and, because he also became troubled symptomatically by insomnia, diarrhea and ejaculation praecox, he returned to the hospital after an absence of about a year. In renewing the therapy, rapport was regained and an attempt made to extend the patient's insight into the escapist and regressive dynamisms of his escapist behavior, their inevitable failure and the more satisfactory ways still available to him for achieving his ends. After several interviews the patient was again almost symptom-free and was even beginning to consider certain advantages that might accrue from his marriage, when another event changed the situation: his father died and left an insurance estate of some four thousand dollars to the patient. Though still hospitalized, he quickly decided that what he needed "to restore his health" was "good food, a lot of sunshine and a long rest," and departed for an expensive southern resort. Six months later he returned home with his funds gone, again began drinking heavily and was once more brought to the psychiatrist. Once again he

condemned his recent behavior and professed contrition and regret—then, also as usual, began to complain that he had been “misunderstood” by his family, who, he asserted, were becoming callous, “just because I’ve had to spend some money on my nerves.” The patient was resistive to further suggestions for a period of abstinence from alcohol and renewed psychotherapy; instead, he promised vaguely to “work it out all right again Doc.” Two days later he “accidentally” skidded a car he was driving into a slowly moving train, settled out of court for an undisclosed sum as compensation for minor injuries, and again departed for the South. When last heard from he was in a private sanatorium diagnosed as a “schizoid personality and chronic alcoholic.”

*Comment.* This case illustrates a number of features frequent in this group of personality disorders.

1. The development of the deviant behavior in the setting of an adverse family environment. It should be noted that the “adversity” does not necessarily consist of economic, educational or social deprivations, but rather of the fixation of behavior patterns in childhood which tended to make the patient’s extra-familial adjustments difficult or impossible.

2. The patient’s active demands on society (“the world owes me a living”) as a continuation of his childhood attitudes toward his own family, and as a function of his lack of training in self-reliance and self-support.

3. The covert hostilities against both his family and society in general when such requirements were—in his interpretation—subsequently ignored in later life, thus giving rise to conflict between his needs for dependence and aggressivity toward those who deny his demands.

4. The “acting out” of this conflict in his highly ambivalent relationships with his family, his fiancée, his employers and, transferentially, with the psychiatrist. This was shown in a number of ways, e.g., (a) his excessive levies on their patience and tolerance—a compulsive testing-out of the extent of their permissiveness, (b) regressive refusal to take an adult role himself in any sphere—social, occupational, sexual or marital (cf. his “psychosomatic” impotence), (c) the aggressive preemption, even at the price of some personal danger (“accident-proneness”), of social care and indulgence, through “accidents” and lawsuits when other forms of support were not offered him freely, (d) the revengeful satisfaction the patient derived from the disappointments his “personality disorder” caused his family, his fiancée, his physicians and society in general, and (e) the patient’s resort to alcoholism as a ready nepenthe whenever his other neurotic escapes proved inadequate.

It is evident, then, that with such patterns of conduct rigidly fixed, the prognosis was at best unfavorable. In therapy, an initial purchase was obtained by utilizing the patient’s regressive dependence, however neurotic, for the formation of a working transference. This influence was then

combined with an easing of the demands made on him by his fiancée to guide him into tentative occupational and social adjustments. However, as soon as the environmental demands again became even moderately pressing, the patient's fragile shell of cooperation broke down and he reverted to his usual patterns of preemptive dependence, covert hostility, alcoholic addiction and regressive narcissism.

#### **Psychophysiological Reaction in a Borderline Character (DSM II 301.9)**

The following case history is cited because (a) it illuminates the kaleidoscopic variety of personality deviations that may be masked by the prominence of some outstanding complaint such as hysterical amaurosis, (b) it illustrates the admixture of conscious intent ("malingering") and secondary gains with less conscious dynamisms in the production not only of psychophysiological dysfunctions, but also of a more dramatic and sweeping "hysterical psychosis," and (c) it demonstrates the relatively simple methods that may be employed in the therapy of the immediate symptoms.

*CASE 3. Schizoid personality (DSM II, 301.9) with functional amaurosis, homosexuality (302.0) epileptiform seizures (301.3) and hysteropsychotic manifestations (300.14).* A 20-year-old girl was admitted to the Clinics with but one presenting complaint. She had "gone completely blind" six months previously and had been unable to find an eye doctor that "understood the case." A psychiatric survey revealed the following:

*Course and Duration of Primary Complaints.* The patient stated that since the age of about 9, she had been having occasional difficulty with her vision; however, she could at present describe these difficulties only vaguely. Three years previously, following some familial and sexual stresses (to be detailed later), she also began to experience attacks characterized by feelings of "fright and shaking" followed by irregular epileptoid jerkings of her extremities. These persisted for about six months. Later in the same year, after eight weeks of employment as a student nurse at a state hospital, one evening she suddenly became highly excited, began to "imitate the manic patients" and continued this bizarre, uncontrolled hyperactivity for several days. When the patient was sent home this behavior cleared, but she continued to complain of symptoms of self-diagnosed "gallbladder, stomach and kidney trouble." Five months before her admission, the patient stated that, again suddenly, she had lost her eyesight except for the barest light perception. After a five-week period at home, during which her vision showed no improvement, she came to Chicago of her own volition and entered an eye hospital. Exhaustive investigation over a period of several weeks revealed no ophthalmic or other organic disease, and the patient was referred for psychiatric diagnosis and treatment.

*Personal History.* Soon after the patient's birth, violent quarrels between her parents began, and some of the patient's earliest memories were concerned with

scenes of verbal and even physical combat between her drunken father and embittered mother. At an early age, the patient also began to have temper tantrums when crossed and to "lie kicking and screaming on the floor until she was blue in the face." For these activities, she was usually spanked promptly by either her mother or father, but only the latter's chastisement seemed ever to be effective. These episodes continued until the patient was about 8 years of age, after which, "because I was continually told how much better my sister behaved," they gradually abated. Other abnormalities which the patient remembered and which were confirmed by the only other informant, her sister, were the following:

A phobia for animals and especially for insects. In the presence of the latter, the patient, in her early years, would scream, run or faint. This phobia still persisted in lesser degree and was associated by the patient with memories of her sister's habit of "collecting little crawling things."

An aversion to water which kept the patient from swimming and made even taking a bath an ordeal. A peculiar variant of this was a persistent dislike of turning on a faucet and an unexplained anxiety that whatever is under the faucet "will fill up and run over." In an Amytal interview, she associated this anxiety with her mother's "nasty habit of douching all the time."

A preoccupation with the number four, never adequately explained. Even in early childhood, the patient would repeatedly count to four, arrange her toys in fours, take four teaspoonsful of food, etc., leading to numerical obsessions throughout life.

With regard to her family relationships the patient, from her earliest recollection to about the age of 9, was definitely more attached to her father. Thus, she would manage to remain near him when he was home, would crawl into bed to play with him and would respond to discipline from him much more readily than from anyone else. Later, however, she began to resent her father's recurrent drunkenness and to be ashamed of his actions at home and in public. Toward her mother, her feelings had varied; she remembered no deep maternal attachments in early life, but later the mother was a haven of refuge from the brutality of the father in his alcoholic sprees and was respected as the only comparatively stable member of the family. Nevertheless, the patient recalled having resented her mother's tendencies toward hypochondriasis, her neglect of the household and her favoritism toward the patient's younger sister. With the latter she had never been particularly intimate, and between the ages of about 7 and 16, she was actually envious of and antagonistic to her as the favored child in the family. Conversely, the patient cherished the memory of a childless, indulgent aunt with whom the patient stayed a great deal in her early childhood.

*School and Early Socialization.* The patient progressed through grammar and high school with good marks and graduated at 17 with a college scholarship. She made only a few acquaintances in school and exerted no effort to join extracurricular activities among the students because "she just got bored with that sort of thing." Instead, she formed a succession of rather deep attachments to elderly teachers, all female, whom she said she respected and, according to the sister, "hero from high school the patient refused a scholarship because she "did not want to work her way through college."

*Occupational and Later Environments.* While attending high school the patient worked evenings in a library, where she apparently served fairly well. After high school she decided to start training at a state hospital. While there, however, she soon came into conflict with her fellow employees and was forced to resign after only two months. From that time on, aside from a temporary job during a political campaign, she had had no steady employment and had done only housework at home. The environment there had changed but little since the patient's childhood: the father was still almost continually alcoholic and improvident and there was either constant bickering or violent quarreling between the parents over financial and household matters. Nevertheless, while the patient's sister had become more emancipated and outgoing, the patient had been content to remain at home and had made no friendships other than becoming intimate with and dependent upon a neighbor woman as described below.

*Medical History.* This was colored with the description by the patient of a large number of poorly defined illnesses since childhood, including the following: measles, mumps and chickenpox, recurrent tonsillitis in fairly severe form with tonsillectomy at about 4; vague abdominal complaints only partially benefited by an appendectomy at 14 and, since then, irregularly recurring upper abdominal pain, nausea, dysuria, head colds, headaches, "sinus trouble," etc. Nevertheless, she did not drink liquor or take drugs habitually, and smoked only moderately.

*Sex History.* The patient stated that ever since she could remember, her father had persisted in attempts to fondle and caress her. During her childhood he would make opportunities to handle her while she was nude and in her bath or elsewhere, would stroke her genitalia and her breasts or would violently embrace her, although she now remembers no exhibitionism or masturbation on his part. Until she was about 10, the physical stimulation she had received in this manner would give her definite pleasure, although she did not experience orgasm. Then, however, she began to acquire sex information from various sources, "realized" the nature of her father's activities, became "horrified" that she had ever permitted them and so began violently to resist his advances. Nevertheless, since the age of about 12 she had on numerous occasions felt sexually attracted to her father, would peek at him through keyholes while he was dressing and would even arrange to be left alone with him in order to be subjected to and "fight" his anticipated advances. These had taken various forms short of actual intercourse and had continued to the present.

The patient began menstruating at the age of 11. Her periods had always been irregular in occurrence, duration and amount and had usually been accompanied by abdominal cramps. She denied masturbation, stating in reference to this, "with my father around, I guess that took the edge off any wishes on my part to do that."

*Present Illness.* As outlined above, the patient began exhibiting behavior aberrations such as phobias and tantrums at an early age. When she was about 9 these abated and seem to have been replaced by chronic somatic complaints carried over from periods of acute illness. One dysfunction, that had persisted with great tenacity since an attack of measles at about the age of 8, concerned her eyes; the patient at various times had claimed that her vision was spotted, blurred or dim—a complaint reinforced by the added regard and attention she obtained from various

female teachers who were "proud that I could do such good work for them, even when my eyes were bad." Later, however, she may have had another incentive for amblyopia which she spontaneously described as follows: "When I was having that horrible trouble with my father, a funny thought used to come to me. I was terribly ashamed and always put it out of my mind quick, but it used to come back. It was this: maybe if I really got blind, I wouldn't be able to stop my father from doing what he was always trying to do to me." Various oculists were consulted at the time, who prescribed glasses and medication, but she always refused prolonged eye treatment on one pretext or another.

About four years before her admission the patient learned that her father, during one of his alcoholic sprees, had attempted unsuccessfully to rape her sister. She suffered a mixed emotional reaction which she now analyzed as having been composed of "anger," "resentment... deep disappointment," followed by what she called her first "epileptic attack": she became "stiff all over," fell and remained "unconscious for about an hour." On awakening, she not only told her mother about her father's attempt on her sister, but for the first time she also related his previous sexual advances to her. The mother seemed neither impressed nor alarmed and remarked simply that "men are like that when they're drunk," an attitude that the patient remembered incensed her all the more. Since her first "seizure," the patient had had four or five others, all precipitated by quarrels with or over her father. In subsequent episodes, the patient also entered into "tonic and clonic convulsions" (terms she obtained from her readings about epilepsy), but in none were there aura, incontinence, tongue-biting or other injury, or true unconsciousness. A physician called during one of these attacks termed it hysteria.

A year later the patient, because she had "always been interested in psychology and mental troubles," entered a course of training as a student nurse at a state hospital. She was "very interested in everything" but almost immediately got into difficulties with her associates and superiors on these grounds:

She thought she was being given "too much work and responsibility." She felt equal to the latter but not to the former.

She resented being "bossed around by orderlies who knew I was more intelligent than they were and would be above them just as soon as I graduated; and they didn't like it when I told them so."

"Being around insane patients sometimes made me scared for myself, especially when I remembered about the insanity in my own family, my father's drinking and all that sex trouble."

The patient's difficulties came to a head when she was accused of having been careless in handling narcotics, an offense for which she was called to the administrative office. There she experienced another period of anger and excitement, following which she suddenly began to imitate various manic patients in her ward. This bizarre hyperactivity persisted for about three days but cleared promptly after her return home. With reference to this episode, the patient at first stated only, "I can't remember much that went on during those last three days at the hospital, and I hate to talk about it. But it was such a relief to get home." Later, however, she recollected her anger at the supervisors, and the satisfaction she derived from her exhibitionistic and aggressive pseudomanic activity.

Following her discharge from the hospital she remained at home, doing little more than helping with the housework. She continued to complain of vague somatic ailments and, especially after quarrels with her father, of increasing difficulties with her vision. She continued to go to optometrists and to bring home dour prognoses about her failing sight, but, as ever, refused to take treatment or wear corrective lenses.

Eleven months before admission, the patient made the acquaintance of a Miss T., a neighborhood spinster fifteen years her senior. Miss T. took a liking to the patient and confided to her stories of her own disappointments in love and at not having married and raised children. Further, she was very sympathetic about her patient's failing vision and would grant her a great many little indulgences and attentions. The patient almost immediately became strongly attached to Miss T., with a large component of physical attraction. This took the form of sexual arousals which were stimulated by mere proximity to Miss T. and by occasional hugs and kisses, although these demonstrations never reached overt mutual masturbation. The patient further stated that after the establishment of her intimacy with Miss T., erotic feelings toward her father ceased and that she even felt no particular resentment when he openly accused her of having actual sexual relations with Miss T.

However, some months later, another girl, K., several years the patient's junior, came to live with Miss T. and to divide the latter's attentions. The patient immediately disliked this girl interloper, and resented particularly her physical demonstrativeness with Miss T., which went on to an extent which the patient says she never permitted for herself. Following the advent of K., the patient, apparently for the first time, began thinking of marriage and decided that it might be advisable to cast about for a husband. She recultivated an acquaintance whom she had previously admired because he was "a better type of boy—quiet and sensible," but, after one or two dates with him, during which there was some mild sexual stimulation, she learned that he planned to marry someone else. She immediately "gave him up," but at the same time began to think, in her own words, "that maybe I have been missing something in life; sex, after all, is a natural and important part of it." Accordingly, the patient resolved to experience her first heterosexual relationship and, with this in mind, arranged a date with a man she knew would attempt to have intercourse with her. After an evening of dancing and some drinking, the man, almost as scheduled, began to make sexual advances. The patient stated that his first caresses were pleasurable but when he became persistent and attempted actual intercourse, she obsessively recalled her father's many previous attempts along the same line, experienced a feeling of deep revulsion and abruptly terminated the sex play. During the next two days, she was moody and depressed and obsessed with the half-formulated thought that perhaps she could never bring herself to have satisfactory heterosexual relations at all. She returned to Miss T., whom she had avoided for a week, with a sense of relief.

On the evening of the third day after her unsatisfactory heterosexual experience, the patient went to Miss T.'s house in anticipation of an automobile ride which she had planned to take with her alone. There, however, she found K., who joined them on the ride, insinuated herself into the seat between them and seemed to be particularly demonstrative to Miss T. that evening. The patient deeply

resented K's. actions and, after a period of moody silence, attempted to veer the conversation around to her eyes, stating that an oculist had told her that every day that she had only a "50-50 chance of preserving her vision and then only if the very best care was taken of it." Miss T. listened sympathetically, but K. persistently changed the subject. At the termination of the ride, Miss T. and K. were deep in a conversation of their own and Miss T., in order not to interrupt this, even asked the patient to get out and open the garage door. The patient did so, but stated that "in that moment, it seemed to me as though I had lost Miss T. forever." While the door was being opened, Miss T. flashed on her bright lights and at that instant the patient "suddenly realized that I couldn't any longer see the headlights, or anything else around me." She cried to Miss T. that she had suddenly become blind, and was taken home by her in an atmosphere of deep sympathy and contrition. The patient frankly enjoyed the greatly increased care and concern that her family and Miss T. lavished on her up to the time of her entry into the eye hospital. She insisted that she really believed herself blind and was sincere in her desire to be cured of her affliction; nevertheless, she welcomed a prolonged stay at that institution and was deeply disappointed when she was referred to the Psychiatric Division for further diagnosis and therapy.

*Physical and Neurologic Examination.* The patient was a short, obese individual with round shoulders, pendulous abdomen and breasts and coarse, though fairly attractive features. The obesity was generalized and not accompanied by any typical hirsutism, possibly indicative of pituitary dysfunction. The only other significant physical findings were a chronic bilateral maxillary sinusitis, and an internal strabismus on near fixation. Aside from the latter, ocular examinations and those of consulting ophthalmologists showed completely normal findings.

*Laboratory Reports.* Entirely normal. Basal metabolic rate on admission was plus 17; a recheck four days later read plus 3.

*Mental Status Summary.* For several days after admission the patient remained tense, talked in a low, measured voice and still claimed to be almost totally blind. The only other peculiarity in her behavior consisted of occasional outbreaks of loud laughter, which she would stop abruptly and for which she would offer no explanation other than the statement, "I can't help it." In mood, she said she "was happy, despite her blindness, but that she really wouldn't like to go home just yet." She denied hallucinations but stated almost unconcernedly that she had seen "imaginary people" while in her "nervous breakdown" at the state hospital. However, these fantasies had not been accompanied by ideas of reference of influence. She again mentioned her phobias for insects and water but gave no further explanation. She was completely oriented, and tests of concentration, recent and remote memory, general information, calculation, association and recollection were consistent with an average or high average intelligence. Replies to other questions were often formalized; e.g., "I am here to receive treatment for the nervous and mental condition [sic] I've placed myself in. . . . I've lost control of my mind but it's not organically affected." On further inquiry, she explained that her blindness was due to a literal "nervous breakdown" in the nerves supplying her eyes.

*Course in Hospital.* In a preliminary interview in the Clinic admission room, it was noted that she moved about with fair facility despite her professed blindness

and gazed everywhere except directly at the examiner; on one occasion when her glance did fall on him, she blushed. Asked indirectly about these phenomena she replied, "The doctors tell me there's nothing wrong with my eyes, so I guess I'm just hysterically blind." However, that there was conscious pretense in her blindness both before and after her admission to the ward can be judged from the following items concerning her behavior:

She learned the layout of the rooms, lavatories, etc., with facility far greater than could be attributed to her assumed habit of walking about with her hands along the walls.

In a letter home she wrote evenly, in parallel lines, crowded the letters together at the margin of the paper, inserted dashes in the proper places, etc. Further, she described the rooms in great detail, even to the type of wood used in the furniture.

In occupational therapy, she at first spontaneously picked out perfectly matched colors for a bag she was making, then, realizing the slip, asked the therapist to pick them for her.

She would ostentatiously bump into obstacles placed in her path if anyone was watching, but would always show reflex protective movements with her arms just before the collision.

On one occasion she had a visitor whom she had not seen since their first meeting while the patient was "blind" at the infirmary. However, she recognized the individual immediately even before the latter spoke.

Various tests confirmed our suspicion of a conscious element in her blindness. Thus:

In the psychologic laboratory, she was asked to press a key in response to the simultaneous noise of a buzzer and the flash of a fairly dim light. After several trials, she pressed the key promptly when stimulated by the light alone.

In a special ocular examination, not only did her pupils react normally to the flash of a light, but she also blinked actively. When she explained this on the basis that she had retained perception of strong light stimuli, the following test was tried: in a dim room, glasses were put over the patient's eyes and then a thin stream of water was directed against them without permitting the water to reach her face. In response to this stimulus, which could have consisted only of a sudden appearance of an almost translucent film of water in front of either eye, the patient once again dodged and blinked just as the stream of water hit the glass.

*Therapy.* In her relations with the staff during the first several days the patient was guarded and reticent, but as rapport was cultivated, she became more frank and productive, allowing the history detailed above to be obtained. Advantage was then taken of her confidence and her pretenses at psychologic sophistication to reassure her repeatedly that her eyes were organically sound, that her blindness was only a "functional disturbance" resulting from an unsatisfactory solution of "inner mental conflicts," and that as she verbalized these conflicts in "cathartic therapy" she would have an "abreaction" and her blindness would gradually or perhaps even suddenly disappear without any particular manipulations on our part. At the same time, other forms of suggestion and encouragement were used; e.g., recovery of vision was made to appear attractive in that it would answer Miss T.'s prayers for her, restore their friendship and possibly even eliminate K. by demonstrating the

patient's greater worth. Concurrently, tests were so arranged as to demonstrate to the patient that, in fact, she was really progressively recovering her eyesight. The final factor that precipitated her symptomatic recovery seemed at first trivial, but proved remarkably effective: the patient was told that an accumulation of Christmas cards, five of them from Miss T., was being held in the office until she had recovered her vision sufficiently to read them, which everyone hoped would be before Christmas. On the afternoon of the 24th of December, the patient, after a period of silent brooding in her room, suddenly rushed out into the corridor exclaiming, "I can see! I can see!" Subsequently she responded normally to every visual test, even to reading fine print, although she still claimed that the latter was somewhat blurred and stated that she "wasn't as yet sure my vision will last." Nevertheless, the patient continued elated and, after some reassurance, was convinced of the idea that the recovery of her vision was permanent.

She was then given as much immediate gratification as possible by congratulations first from the staff members and then from her family and Miss T., who were summoned as soon as possible to witness the happy event. To bind the immediate symptomatic improvement, the patient was also granted various privileges she had long coveted, among them being minor responsibilities in assisting the nurses, which gave her a special status in the ward.

With the recovery of vision, however, other behavior difficulties reappeared; she became demanding and preemptory in her dealings with the nurses and other patients, insisted on her "professional prerogatives as a student nurse," and even accused an intern vaguely but stridently of "an improper attitude" while performing a routine pelvic examination of another patient—despite the fact that this was done with usual decorum and nursing help. However, since she professed to be completely well and there seemed to be little prospect of successful therapy of her deeply rooted character aberrations, she was discharged in care of her mother to return to their home in a western state.

The subsequent course of this patient is interesting. Two years after she left the hospital the therapist received the following telegram from her (obviously transmitted by a quite unimaginative operator):

"I am pregnant [with ideas] and will not abort [them]. Psychoanalysis is now in order [by person not pen]. I fear to take your time but may I have your leisure trusting [thrusting] you understand. Am leaving tomorrow."

On the strength of this, the patient's family was called by long distance and asked about her interim history and present status. A long letter arrived from the patient's father and her local physician with the following information: The patient after her return home no longer complained about blindness but refused to consider steady work, partly because of various other vague physical complaints, but mainly because she thought that there was no position available in the community suitable to her talents. She developed a deep antagonism to Miss T., and on several occasions provoked public quarrels which disturbed the neighborhood. At home, she spent most of her time reading books on abnormal psychology, eating frequently, and becoming increasingly demanding and provoking. A week previously, her father had lost patience and ordered her out of the home. The patient had created a

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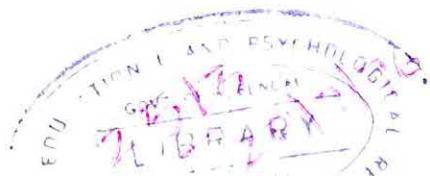
violent scene, at the height of which she suffered an "epileptic attack," during which she tore her clothes and exhibited erotic and aggressive movements. Since then other "attacks" had alternated with similarly uninhibited behavior which the patient herself diagnosed as "manic," and for which she demanded return to the University hospital for another "cure."

The patient's physician was advised that, in view of the hardship it placed on the family, it was probably unnecessary to arrange for her return to the University hospital and that she could be cared for by several qualified specialists nearer her home, whose names were furnished.

A report from a state institution a month later stated that she had been committed there, diagnosed as in a "manic phase of a manic-depressive psychosis" and given Metrazol shock treatment. Two shocks had been sufficient to "cure" the patient and, although she "still seemed a little disturbed," she had been discharged home.

*Comment.* This case may be used as an illustration for almost every form of psychopathology, including various transitions into psychotic behavior, but particularly instructive are the following:

1. The almost infinitely variegated arrays and combinations of "neurotic" symptoms: free anxiety, phobias, compulsions, psychophysiological dysfunctions (including epileptiform seizures and hysterical blindness) and homosexuality, as well as more sweeping disturbances of behavior such as schizoid fugues and pseudomania.
2. The successive prominence of one or a few of these reactions under varying circumstances, although patterns for all of them were established in early life and remained latent thereafter in the patient's "neurotic character."
3. The emergence of differing configurations of neurotic and psychotic behavior as best suited the patient's purposes, whether these were conscious, unconscious or, as is operationally always the case, both: for example, the appearance of frankly aggressive demands for attention and special privilege when the hysterical amaurosis was grudgingly relinquished under therapy. At the same time, the patient avoided openly antisocial (sociopathic or criminal) acts as an index of her relatively strong inhibitory functions (sometimes miscalled "ego strength"), springing from her need for interpersonal security.
4. The appearance, nevertheless, of pseudopsychotic behavior (patterned according to the patient's avid observation of and reading about psychotics) whenever the patient was intensely moved by wishes for (a) partial release from sexual or aggressive inhibitions, (b) social toleration of such release on the grounds that she was having a "nervous breakdown" or was "temporarily insane" and therefore irresponsible, and (c) a desire for a symbolically regressive return to the care of a presumably indulgent and

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nonthreatening psychiatric milieu where the patient could for a time play the role of an irresponsible infant. It need hardly be pointed out that under such circumstances the patient did not become wholly psychotic, in that, despite her hyperactivity, emotional lability and highly symbolic fantasies, her behavior continued relatively integrated and goal-directed in a deviant but socially oriented fashion. It was to be expected, therefore, that when, instead of landing at the University Clinics in her final pseudomanic reaction she was instead committed to a state hospital and given shock therapy, the treatment had immediate and apparently salutary effects on her current patterns—without, it may be justifiably presumed, altering significantly her deeply neurotic propensities.

### **The Pseudosophisticate**

A type of personality disorder rather common among the youth of recent years is the self-consciously blasé misanthrope who attempts to compensate for subjective inferiorities and objective failures by consciously or unconsciously affecting an air of cynical sophistication and disillusionment. Such a case is the following:

*Case 4. Passive-aggressive personality (DSM II 301.8) with dysocial behavior (316.3).* A 20-year-old youth applied for admission to the Clinics with the statement "I'm fed up with life—bored to death at twenty! I'd shoot myself tonight if I could get a pistol! But before that I'm curious to know what makes me a manic-depressive." Although the danger of suicide was not taken seriously, the patient was admitted for observation. His case record may be summarized as follows:

*Family History.* The patient's father was a personable, intelligent but unscrupulous individual who had led a roving uncommitted life. He had worked erratically and was frequently fired for derelictions or minor dishonesties, but had always managed to convince someone else to hire and trust him again. Three years before the patient's admission to the hospital his father, in a mood of defiance toward an unappreciative world, had "gone on relief." In a characteristic gesture, he had offered the agency his services as an office clerk "to pay them back," but was soon embezzling state funds and had recently been sentenced to jail for a term he was still serving. Nevertheless, the patient admired his father's "culture" and considered him to be misunderstood and harshly used by society. Most of the patient's enthusiasm, however, was reserved for his mother, whom he "loved like an Oedipus complex, you know." The mother had married the patient's father when she was only 15, and had "traveled all over the country with him—the three of us, like three wonderful gypsies"; moreover, she was not only "cheek" and "peteet," but he considered her "infinitely smarter than the fat stupid women she has to make dresses for just to make a living."

*Past History.* The patient was the only child and, according to him, was told at the age of 2 that he would never have brothers or sisters because his parents

"wished to devote their lives only to him"—in all probability, a wishfully determined *screen memory*. At 5 he entered kindergarten, and although he had attended nine different schools, he never graduated from the grammar grades, usually being expelled after a period of two or three months for episodes of truancy, during which he attended morning movies or played in a park. When he was 16, at the intervention of a self-styled "modern educator of youth" who believed in "meeting the challenge of our emancipated young men," the patient, without proper preparation, was permitted to enter a "progressive high school." There he "thoroughly enjoyed the fraternity life, the kids were socially cultured—they gave me room to maneuver"; however, his maneuvers even in a permissive milieu again led to his expulsion in less than two months.

*Occupation.* Since this termination of his academic career the patient had briefly held eight different jobs, as bellhop or elevator operator, with intervening periods of idleness of two to four months' duration. He either quit these positions as "too monotonous" or was fired for inefficiency and tardiness.

*Social Adjustment.* The patient stated that even as a small child he had difficulty playing with other children, because they "bored" him or were "mean" to him. He preferred the company of older people, especially those who appreciated that he was "smart and witty." In school, he made no permanent friends and always tried to impress others with his superiority; when his bluff was called, he simply sought a new group to impress. Recently, he had also become estranged from his mother because she, too, was becoming "too critical of my being a bohemian thinker—maybe she's losing her touch."

*Habits.* The patient had smoked 30 to 40 cigarettes daily since the age of fifteen, and had lately experimented with "pot and a little acid"—marihuana and LSD.

*Sexual Development.* The patient stated that he had practiced frequent masturbation ("with images of my mother, of course") since "age 7; I was ahead of my time," and after 15 had "been very promiscuous—women go for me." One year ago, he had oral homosexual relations with "a good friend" in order to "round out my sexual experiences." He vomited, "but so what?—it was only my first time." Three months ago, he fell "seriously in love" with a B-girl at the——Inn. He considered marrying her, but she terminated their sex affair because she "couldn't see her future in it right away." The patient added that he thought "it was just as well, as she was, after all, spoiled, mean and inconsiderate, and hurt my feelings."

*Present Difficulties.* After the patient's father was sent to prison the patient was forced to move to a suburb to live with an aunt and her children whom he considered "inferior, uneducated and misunderstanding." However, he could not escape their society, nor could he indulge in movies, which were now his chief form of escape. He sulked about the house and became "bored," "disinterested" and "disgusted." He returned to Chicago and again secured work as an elevator boy but this also bored him. For a time he "decided to enter show business," but further research revealed that "the field was too narrow." He thought that he would rather "stretch out his hand to culture," but to achieve culture either a year in Europe or a college education seemed prerequisites. He told his mother and relatives of these needs, but was reminded that the plans would take money which was not at hand.

and that college would require the passing of an entrance examination. These materialistic quibblings made him very unhappy, whereupon he "became very introspective and nervous," tired easily and lost all his "ambitions and interests." He then began to suffer "depressive phases," in which he refused to speak with his family and "thought life was not worth living." He therefore applied to a public agency and was sent to the University hospital with a note from a social worker to the effect that "he was an interesting diagnostic problem and we all hope a possible case for psychoanalysis." The patient had agreed to come because, although he knew his own diagnosis and also that "nothing could be done for manic-depressives—they're just too sensitive," he could nevertheless "exchange opinions with the hospital psychologists and so round out my cultural experiences."

*Medical.* The physical, neurologic and laboratory findings were essentially normal.

*Psychometric Test. I.Q. 95*

*Course During Hospitalization.* The patient preferred to sleep during most of the day, and associated very little with other patients, since he considered himself very superior to "the other nuts that you have here." He was surly to the nurses and attempted to dominate them by making demands in very positive tones; when rebuffed, he became easily discouraged. Under such circumstances he would try what he called his "witty way":—"Hi babe, give me a match—dig what I mean?" He described his mood variously as "terrific," "deep melancholy" or "pensive" (a term he heard used by one of the interns), but at no time were there signs of true depression or manic excitement.

*Formulation and Therapy.* At a superficial level, it appeared that in his callow pseudosophistication and demanding dependence the patient was trying to emulate his father, with whose social irresponsibility he avidly identified. As to why this should be so in view of his father's fate was made clear in separate interviews with the patient's mother, a flighty, gullible woman of limited intelligence, who quite readily indicated that she had not only accepted such behavior from her husband and son, but had taken pride in the fact that her men "were always different—not like ordinary. My husband always said he wouldn't be no John Doe. And I guess Sonny just natural inherited that too." With such familial norms ingrained early, all later evidence as to their unacceptability in other social circles was either ignored or else taken as a further occasion for reversion to childlike fantasy and bragadocio. These recurrent maladaptations and failures have occasioned the clinical aphorism: "sociopathic personalities don't learn by experience"; however, the word "experience" in this dictum, literally taken as meaning "to pierce through," must be interpreted according to the dynamics and symbolisms of the subject involved. In this case, what others would "experience" as objective economic and social failures had for the patient paradoxical advantages: e.g., identification with the father, a pose of social defiance and sanctioned regression to maternal or surrogate institutional care, all rationalized on the basis of a pretended superiority to the cultural mores and obligations of the "common man." Even the repeated talk of suicide had the tone of the child who threatens to run away from home because he hasn't completely had his way—with the expectation that this will of course make all concerned promptly mend their manners and services. Under such circumstances,

therapy was, if not altogether impossible, handicapped by the patient's limited intelligence and talents, by adverse and still potent familial influences, by quasi-permissive social agencies, and most of all by the patient's lack of incentive to face the deep anxieties and disillusionments should his cherished personality patterns be undermined.

Therapy, then, would be possible only under circumstances of (a) prolonged and, if necessary, enforced supervision of special camps or institutions such as are set up for this purpose in some European countries, (b) formation of an initially dependent transference on a therapist who could both implicitly and explicitly inculcate more practicable personal identifications and social goals and techniques, (c) a rehabilitative group environment in which the patient could test these techniques and eventually adopt those leading to serviceable acceptances and loyalties and, finally, (d) adequate bridges between these partly controlled reorientative experiences and their application to the general social milieu. Since we have no such legal or institutional facilities—and, because of the dangers of abuse, perhaps should not have them in a democratic society—the therapy of the sociopath is often beset with practically insurmountable difficulties.

As is often true in such cases, the patient himself, for the moment at least, resolved the therapeutic impasse by deciding he had assimilated as much culture from the hospital as he needed and once again departed for parts unknown.

### **The Criminologic Personality**

Not infrequently a relevant and important question arises with regard to sociopathic patients: can they not be *made* to discharge their just obligations to society, especially under circumstances of universal needs to which everyone else is constrained to adapt? The following is a case in point:

**CASE 5. *Antisocial personality (DSM II, 301.7): Relation to military service.*** Toni L., a 20-year-old Italian youth was rejected by military examiners as "unfit for armed service." This decision, however, was contested by his Selective Service Board, who considered him a "misguided" but able fellow, and who thought that "the Army would make a real man of him." His anamnesis can be summarized as follows:

*Early History.* His parents had been brought to America in their early teen and had found new opportunities for education and economic advancement in this country. The father, who had developed into a petty gambler and minor machine politician, had married the patient's mother, an illiterate immigrant girl of 18, and thereafter had given his family little guidance or security; moreover, in later years he had become alcoholic and abusive. The patient's mother had had little time for anything but household drudgery, frequent childbirth and religious devotions. She had neither the time nor capacity to grasp her children's problems as they grew up in what was to her a foreign environment beyond understanding. Accordingly, when her initial attempts at strict old-country discipline and her efforts at religious teachings failed to make any impression on them, she could resort only to simple

menial services, spread—necessarily—somewhat thinly among the nine children in her brood.

Toni was the second of the nine, and was scarcely a year old before his mother had to shift her attention to his newborn sister. At the age of 2 he was toddling the streets of a Chicago slum unattended; at 6 he and his elder brother were already members of a semiorganized street gang, the moving spirits of which were juvenile delinquents. With little security and less guidance at home, Toni quickly identified himself with the ideals and ways of life of these apparently successful leaders, and the unwritten code of the "gang" became his measure of "right," as rewarded with belongingness, safety and satisfaction, or "wrong," entailing, insecurity through group punishment or ejection. Though it was never formulated by anyone, this code clearly held that it was right to be "smart," i.e., steal or lie to one's advantage and live idly by one's wits, and "tough": aggressive and domineering toward everyone not identified with the group. On the other hand, it was wrong to be "chicken," submit to parental, educational or social (especially police) discipline; "dumb"; get caught at anything, or what was worst of all "to rat" (i.e., be disloyal to the leader or any accepted member of one's "gang"). To Toni, then, most teachers or principals and all policemen were by definition personal enemies unless they proved themselves otherwise—which few of them troubled to do. Such persons were to be obeyed only insofar as was absolutely necessary, and outwitted and frustrated whenever this was advantageous. In his short schooling, therefore, he was as truant as it was safe to be, and in jobs after school he soon began to cheat and steal up to an accurately judged minimum probability of discovery. Equipped as he was with high native intelligence, a capacity for self-reliant cunning and a sort of hard-shelled friendliness with his own kind, he kept out of serious trouble. Moreover, since he was forceful, personally successful and could be "trusted" to adhere to the code, he gradually became a leader in his group. This rise was, if anything, encouraged by his father, who profited indirectly by the boy's increasing earnings and local status; indeed, the father began to use what ethnic political influence he had to get the lad special considerations from the local police and to keep suspicion off his trail, while the mother remained almost totally ignorant of the direction of her son's development. Other influences on the boy's life were few, but characteristically deceptive. For instance, Toni took a liking to the parish priest and not only kept the church immune from his gang's vandalism but even sang in the church choir—thereby convincing the priest of the lad's inherent goodness and purity of soul. Similarly, there were other "right guys" in the neighborhood, among them well-to-do saloonkeepers and minor politicians who, on Toni's orders, were protected from the gang's bullying depredations, thus adding to Toni's allies in influential quarters.

Toni's subsequent career can easily be surmised from this background. He progressed from petty embezzlements on newspaper collections to acting as a fence for stolen tires, to bootlegging and finally to various types of politically protected graft and gambling. Sexually, he was arrogant and promiscuous—and yet by his own lights strictly moral: his friends' sisters or fiancées were immune and were, in fact, rebuffed when they attempted to seduce him. He remained completely loyal to his group and neighborhood, generous to his family and friends, and indefatigable in working for any sentimental cause that, however unpredictably, appealed to him.

Yet, when he thought the step profitable, he could also arrange to have a local businessman who had offended him ruined by intimidation or actual destruction of property, or with righteous equanimity order a member of his gang beaten severely for some neglect or error. Nevertheless, he was clever and worldly-wise enough to avoid serious difficulties with the police: two weeks of observation in a juvenile detention home (where he was a model of behavior) and occasional futile arrests "on suspicion" had been the total punishment for extortion and other crimes that hundreds of people knew—but could not or would not prove—he had committed.

When war came, Toni was completely uninterested in any of the issues involved except broadened opportunities for racketeering. When Selective Service was established, Toni duly registered, confident that he "could beat the rap—I got friends." At his induction examination Toni was superciliously cooperative, and yet when, on the basis of his questionable police record and psychiatric examination, he was given a IV-F rating for "personality unsuitability," his pride was deeply wounded: that he of all people should be considered "not as good as these other punks." He therefore reversed his stand about "the rap," secured a reexamination and a certification from private physician as to his physical health, obtained "character references" from his parish priest and several local politicians, and so armed, appealed to his draft board for induction. They were, of course, impressed by what they considered his patriotism and the evidences of his reform, and referred him to the advisory board psychiatrist for a possible reversal of the medical induction board's decision.

*Formulation.* The psychiatric problem, then, could be posed as follows: Toni was a healthy, intelligent, courageous, self-reliant and resourceful young man who might, just possibly and under favorable conditions, do heroic deeds in combat. And yet this possibility was rendered highly remote by the following considerations: All of Toni's motivations, far from being altruistically patriotic, were narrowly narcissistic, he hated and feared authority and had never shown consistent amenability to any discipline but his own; he could not cooperate in trust and friendship with strangers—and nearly all the world was strange and threatening to him; and he had given no evidence in his behavior of the long-term endurance, stability and responsibility that are essential in modern military training and group combat. On the contrary, there was every indication that once his pride has been assuaged by induction, he would thereafter resent indoctrination and training as infringements of what he considered his freedom of thought and action and would not only be as chronic a troublemaker in the Army as he had been in civil life, but would eventually place himself at the head of a group of like-spirited rebels to disrupt routine and discipline and endanger the efficiency of their entire outfit.

The consulting psychiatrist was, of course, tempted to send Toni where he might, after all, confute the prognosis and at least serve his country to some extent. But experience, sober judgement and deeper patriotism prevailed. Toni was given a brief course of instruction on how he and his friends could give valuable service at home in allaying racial prejudice, in calming social unrest, etc.—but insofar as military service was concerned, Toni's IV-F status was confirmed. And, in ways that must be kept confidential, Toni served well until a fatal disagreement with a pre-emptive Chicago crime syndicate four years later.

### Personality Disturbances in Reaction to Overwhelming Stress

Cases of deeply rooted personality disorders and relatively fixed sociopathic patterns such as in the patients just described may lead the practitioner to repeated disillusionments and sometimes to generalized prognostic pessimism and therapeutic nihilism. Such attitudes, however, are not apropos to patients with more favorable backgrounds and greater readaptive capacities (in analytic terms, "ego strength"). This is true even when the picture such subjects present may at first sight appear quite ominous as, for example, a drug delirium, an outbreak of furious aggression or a serious attempt at suicide. A case in point is the following.

*Case 6. Transient situation disturbance (DSM II, 307): Alcoholic delirium (303.0): The problem of masochism.* A patient, 27 years old was admitted to the University hospital in acute alcoholic delirium—disoriented, ridden by fearful hallucinations and confusedly amnestic. He made a rapid recovery in two days of rest, mild sedation, hydrotherapy and high caloric feeding, and was then able to give a consistent account of his life experiences.

Briefly, the history revealed that at an early age he had suffered from acute rheumatic fever which left him with painful joints and impaired cardiac function. The father—a self-reliant and highly religious but apparently ignorant and unfeeling man—had then taken a strong dislike to his "weakling" son and had placed numerous obstacles in the way of the latter's schooling, including almost impossibly high requirements as to scholastic performance to compensate for his athletic deficiencies. Despite all handicaps, including the necessity for partial self-support, the patient completed junior college and later, special training for an accountant's certificate. The strain, however, told on his health, and at the age of 21 he again fell seriously ill, was diagnosed as having moderately advanced apical tuberculosis, and was sent to a municipal sanatorium. He took even this serious setback with good grace, cooperated well in his treatment and was making a fair recovery when he became enamored of a girl who had herself recovered from mild tubercular pleurisy and was about to leave the sanatorium. Understandably fearful of losing her, the patient persuaded the hospital physician—who apparently in this instance let his romantic paternalism affect his medical judgment—to permit their joint discharge, and the couple were married soon afterward.

Misfortunes, however, promptly began to pile up at a rate that would not be given credence outside the Book of Job. The patient's wife, dissatisfied with his salary as a bank clerk, insisted that he resume his study for a CPA examination, and the patient, in his devotion to her, again taxed his strength and resistance dangerously. A defalcation was next discovered in the bank's accounts, and for several harrowing weeks the patient was under unjust suspicion. During this period, while he was suspended from his job and under technical bail, his wife left him with no explanation other than a note to the effect that she "couldn't any longer tolerate a physical weakling, and especially a thief." Two days after this, the patient was completely cleared of all responsibility in the bank theft, only to be told by the bank manager who had originally accused him that "for obvious reasons, we can no

longer work together" and that the patient would therefore have to resign his position. That night, in a fit of coughing, the patient for the first time in months brought up blood-streaked sputum—a strong indication that his tuberculosis was reactivated, and quite probably more seriously than ever. With everything gone—job, wife and even marginal health—the patient gravely considered suicide, but then came to a preliminary decision; since sober habits, hard study, honest work and faithful devotion had brought nothing but frustration and sorrow, before he died he was going to have an orgy, however brief, of defiant self-indulgence. Not knowing quite how to go about this, he collected all his available funds and began with what he had heard the men at his office boast of—he went to a locally notorious saloon, picked out one of the most expensive "hostesses" and, for the first time in his life, set out to get drunk. His companion proved very receptive to the idea, bought a plentiful supply of liquor with his money, accompanied him home, and there continued to ply him with drink until he was in a confused stupor—after which she appropriated a considerable fee for her services and left him to his own devices. The next day the patient was found in a state of active delirium by a neighbor who had previously liked the patient as an unobtrusive, friendly person, and who now rightly reasoned that he "must be out of his mind to act this way." Fortunately, the neighbor refrained from calling the police ambulance and instead brought the patient to the University hospital for medical care.

*Treatment.* The patient's therapy was first designed to meet his urgent medical needs and then directed toward his immediate social rehabilitation. A phthisiologist, called into consultation, diagnosed some reactivation of his pulmonary tuberculosis but, fortunately, was able to control it quite successfully by a partial pneumothorax. The cardiac lesion was similarly re-checked and found to be sufficiently compensated to permit the patient a considerable latitude of physical effort. The psychiatrist then took an actively reconstructive role in helping the patient reorganize his affairs. The bank manager was summoned for an interview and came, as was to be expected, partly out of curiosity and partly in a defensive patronizing "I-knew-he-was-queer-all-the-time" attitude. Nevertheless, the psychiatrist, while ostensibly appealing to the manager's humanitarian sympathies, tacitly implied that if the patient remained embittered he might well take justifiable legal action against the bank and its officers; this evoked sufficient concern to induce the manager, with a somewhat hurried air of "Let's let bygones be bygones," to re-employ the patient at an increased salary. Next the patient's wife was similarly interviewed, and her own needs for security and fear of her own friendless ill health were utilized in a manner not only to effect a reconciliation with her husband, but also to make more probable somewhat greater interdependence and consequent harmony in their financial, sexual and social interrelationships. With his most pressing problems thus partially resolved, the patient was discharged from the hospital, but with pre-set arrangements for interviews at weekly intervals to help guide him through the inevitable difficulties of his readjustments and to guard against renewed tendencies to overreactive ambition and overintensive effort. When seen in a follow-up interview a year later, he reported that he had passed his accountancy examinations, had been promoted to the position of chief teller at his bank, was fairly happy in his work and in his marriage and had experienced no further serious difficulties.

*Comment.* There has been a tendency in some precincts of analytic theory to attribute certain behavior patterns exemplified by this patient to be the influence of inherent "tendencies toward self-destruction" springing from a postulated "death instinct." Analysts of this persuasion would essay to explain his serious illnesses as unconscious expressions of self-destructive tendencies under environmental stress, and some would equate the patient's self-induced alcoholic stupor with "partial suicide." Others (e.g., Greenacre, Fenichel), might point out that the patient was also "masochistic" in his choice of wife, his employers, and even of the woman companion on his drinking spree.

And yet, a diametrically opposite theoretic interpretation—namely, that all of the patient's behavior was hedonistically oriented—could be made with considerably more justification with reference to the anamnesis and the therapeutic results. Thus, it is quite understandable that the patient, when he was ill, discouraged and lonesome in the sanatorium, should fall in love with a girl who, by virtue of her similar illness and dependency needs, could be expected to prove a sympathetic and faithful wife. Similarly, his subsequent neglect of his health was to him, a small risk compared to the danger of losing her and his home; so, too, his final fling, while "suicidal" in an escapist sense, was much more a grasping after whatever pleasures and companionships were still available in the face of what seemed to be overwhelming travail. Finally, if we avoid esoteric theorizing, we have little ground for asserting that this patient consciously or unconsciously traduced himself into illness, occupational failure or other misfortune because of "reactive aggression turned upon the self." All in all, instead of behaving in a manner that could meaningfully be called "masochistic," the patient displayed the fortitude of a Job until his adversities became practically unbearable. This appraisal was borne out by his rapid return to normal stability under a therapeutic regimen based on (a) sympathetic understanding of the patient's problems without prejudicial attitudes and formulations, (b) a realistic appraisal of his needs, limitations and assets, (c) a willingness to take an active and not merely a safely aloof passive-observant part in helping the patient within the ethical and professional limits most appropriate to a physician, (d) the skillful utilization of dynamic psychiatric techniques in securing the essential cooperation of people important to him and, finally, (e) not resting content until the patient had become reestablished to the point at which he no longer needed or desired the psychiatrist's aid. As to "insight," that developed implicitly, operationally, and therefore truly effectively throughout the course of the therapy.

### Other Forms of Personality Disorder

There are, of course, innumerable other "types" each of which can be labeled with some particular trait considered outstanding by clinicians who are taxonomically inclined. Freud (*Collected Papers*, Vol IV) distinguished three such "character-types"; (a) *the exception*—i.e., the patient who wishes to think himself uniquely used or abused by nature (e.g., the deformed and bitter Richard III) and therefore justified in exceptional acts; (b) *those wrecked by success*, who cannot, because of their fears of hostile retribution, permit themselves stable attainments in any field of endeavor, and (c) *criminality from a sense of guilt*—i.e., those who by antisocial acts court expiatory punishment.

Other "types" occasionally distinguished are: the recklessly shortsighted hedonist, the affectively imbalanced (e.g., the explosively impulsive, the fixedly pessimistic, the hypersensitive, the moody, the dramatically labile or emotionally cold), the socially contentious ("cranks," litigants), "get-rich-quick planners," the "self-righteous martyr," the fantastic or "pathologic" liar, often for no direct advantage discernible to others or even himself, the narcissist, who must focus every possible situation upon himself, the subhypochondriac, the malingerer, and finally the variety of transvestites or "sexual deviates" (DSM II 302) whose erotic interests and expressions range beyond those accepted by the predominant social milieu. Some psychiatrists consider it advantageous to distinguish such behavior patterns as a whole from standard psychiatric categories such as the psychoneuroses, "borderline" or "pre-psychotic" personalities, and "ambulatory psychoses"; but in general the differential criteria, as elsewhere in psychiatry, will be found to be neither specific nor prognostically or therapeutically useful. Indeed, as Cleckley implies in his *Mask of Sanity*, neurotic and sociopathic personalities may reach high places in the arts, the professions and in politics and industry, and thus feel even less need for psychiatric help than do their less successful fellow men.

*Adult Maladjustments* (DSM II, 316). This heading covers the infinite variety of human reactions to tribulations when these responses are not characterized by overtly neurotic or psychotic behavior. The psychiatrist cannot lose sight of the fact that, interpret his environment as he will, a subject has only limited control over it, and is entitled to become discouraged, unhappy, bitter or sorrowful under adversity. The rejected child, the wife of a brutal drunkard, the outcast cripple, or the penniless, forsaken geriatric patients who develop such reactions are not necessarily "neurotic," but are pathetic and often helpless victims who need social aid rather than psychiatric therapy. It is for such reasons that the psychiatrist must be more than a person possessed of deep human sympathies; he must

be willing and able to help his patients out of their "realistic" as well as their "neurotic" difficulties insofar as is possible and ethical, and he must know and enlist the charitable and social resources of the community to these ends whenever that, too, is necessary.

### GENERAL PROGNOSIS IN PERSONALITY DISORDERS

This of course depends on a number of interrelated dynamic considerations, among them: (a) the amount of anxiety (inner dissatisfaction and apprehension) present as an index of the incompleteness of the neurotic adaptation, counterbalanced by the extent to which the patient's current behavior patterns suit his external circumstances: (b) the nature, depth and fixity of the patient's motivational conflicts and symbol-formations, and (c) the availability of therapeutic resources such as effective external pressures (familial, economical and social), long-term psychiatric guidance and supervision, and opportunities for channelizing improved behavior into permanently effective and rewarding patterns. Unfortunately, not always are these and other vectors favorable; too often, neither sufficient incentive on the part of the patient nor adequate facilities available for good therapeutic results are present, so that many patients, even when given the opportunity for long term psychotherapy, either break off the treatment, or skirt its edges for years without effective insights or significant improvement in behavior. Nevertheless, with favorable conditions and rational therapy, the prognosis is, contrary to the traditional pessimism in the field, moderately good for reasonable and maintained improvement.

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## Chapter 3

### THE NEUROSES: GENERAL CONSIDERATIONS

#### ORGANIC FACTORS

Neuroses (DSM II, Section IV), as distinguished from psychoses by the criteria presented in Chapter 6, have been defined as "functional" disorders of behavior representing suboptimal adaptations to stress and conflict but not requiring institutionalization. However, since behavioral responses to organic disease are also "functionally determined" responses to stress, and since "neurotic" reactions in turn produce organic reflections, two considerations important to the differential diagnosis of neurosis immediately arise:

1. First, it must be recognized that normal findings on physical and laboratory examinations in a patient complaining of an illness do not prove that the illness is "neurotic," since otherwise we must assume (a) that our present medical diagnostic techniques are complete and infallible; (b) that all possible organic diseases are known to the clinician and can be included; and (c) that this leaves the diagnosis of neurosis as the only remaining possibility. Obviously the medical student entering the field of clinical psychiatry must not adopt the fallacious reasoning of "diagnosis by elimination," else he may fall into the facile error of labeling "neurotic" any disorder he cannot otherwise identify, thereby exposing his patient to the grave danger of neglect or mistreatment of early or obscure expressions of organic lesions.

2. Conversely, the presence of demonstrable pathologic changes in body tissues constitutes a threat to which the patient may react neurotically. For instance, a patient with hyperthyroidism may develop anxiety or depressive states because of the adaptational problems as well as the physiologic dysfunctions consequent to his illness. These reactions not only may complicate and exacerbate his thyrotoxic symptoms, but may persist after the thyrotoxicosis itself is cured. Indeed, since all infections, injuries, neoplasms or other pathologic insults inevitably give rise to anxiety and regressive or other responses, a "functional overlay" is inextricably combined with that of the organic illness, and the differential diagnosis does not become a matter of eliminating one or the other, but of their inter-relationships.

These considerations, then, make it evident that the diagnosis of a neurosis must depend not on the presence or absence of organic disease, but on specific criteria related to the etiology, development and clinical characteristics of the neurosis itself. These differential criteria are outlined in the following section.

### **Clinical Criteria for the Diagnosis of Neuroses (DSM II, 300)**

In general, those behavior disorders usually classified as neurotic have one or more clinical characteristics which may be previewed as follows:

#### **Presenting Complaints**

1. *Anxiety*. This term has may subtle and interpenetrating meanings. Derived from the Latin *angere*, it connotes hostility ("you make me anxious") and fear of retribution (anguish) or, conversely, reactive *solicitude* ("I am anxious about your health") and compensatory endeavor ("I am anxious to reach a doctor for you"). However, in the following text it will be used in the psychiatric sense of motivational conflict, apprehensive uncertainty and adaptational failure. These are present during the development of nearly every neurosis and may take the form of an episodically recurrent or continuous *anxiety syndrome* with subjective and physiologic manifestations as described under Anxiety Neuroses.

2. *Subjective and Reactive Deviations*. Obsessions, compulsions and phobias may be developed to mitigate anxiety, whereas their transgression immediately elicits and exacerbates it.

3. *The Occurrence of Sensorimotor (Hysterical) or Organic (Psychosomatic) Dysfunctions*. These may be differentiated from the symptoms directly due to organic disease by the following criteria:

(a) Their lack of correspondence with the semeiology and course of known organic diseases. For example, an hysterical patient may complain of complete anesthesia in both hands (glove anesthesia)—a distribution which could not be accounted for by any single neurologic lesion. More rarely, a patient may profess to see triple images (triplopia) or be unable to walk despite normal muscular strength and control (astasia-abasia).

(b) The tendency of neurotic symptoms to vary greatly in character and to shift from one organ or system to another (DSM II, 300). Thus, as the nature, intensity and symptomatic expression of a patient's neurosis vary with the vicissitudes of his life experiences over a period of years, he may complain successively of headaches, paresthesias, gastrointestinal disturbances, dermatoses, syncopal attacks, and a variety of other symptoms, none of which is of demonstrable organic etiology.

- (c) The onset of symptomatic disturbances under circumstances of conflict and emotional stress (e.g., frustration, deprivation, insecurity).
- (d) The exacerbation of symptomatology when the stress is increased and the patient's adaptive tolerance exceeded.
- (e) The mitigation of neurotic reactions when the stress is relieved. This may occur spontaneously by resolution of or escape from the stressful situation, or as a result of various methods of "psychotherapy." Thus, it is suggestive of neurosis if a patient's symptoms have been temporarily benefited by almost any type of medication, by a change of physicians, by unlikely therapies (including trials of chiropractic and naturopathy) or merely by a vacation from conflict-engendering stresses.

4. *The Function of the Symptom as Denial or Symbolic Expression.* This may be relatively overt, for instance a neurotic paralysis of the right arm which makes it impossible for a soldier to continue in combat. Usually, however, the adaptive nature of the symptom is less apparent. Thus, a young mother who covertly rejects her child may be overly meticulous in its care, or ambivalent oral dependence may be manifest in the psychosomatic dysfunctions of an *anorexia nervosa* (v.i.).

Equally important, though less obvious, are the more generalized deviations of conduct that distinguish the "character neuroses" and the "sociopathic states" as described in Chapter 2.

### **Family and Past History**

The patient's anamnesis should indicate that *his neurotic patterns had been derived from early experiences and that his presenting complaints were precipitated by stresses that specifically affected his sensitivities and so exacerbated his aberrant reaction-tendencies.* Thus, a patient particularly vulnerable to deprivation may react neurotically to a personal loss, yet remain immune to sexual or other frustrations. Conversely, another patient with deep feelings of insecurity may withstand all stresses well except those of threats to his prestige and control.

### **Effects of Therapy**

*Finally, the symptoms may be temporarily alleviated by therapeutic methods applicable only to neurotic dysfunctions.* This "therapeutic test" relates to criterion 3(e) above and includes modalities that are effective for reasons that often remain unrecognized by the patient and sometimes are not acknowledged by the therapist. Examples are inactive drugs in homeopathic doses, the administration of superfluous hormones, unnecessary verbal or calisthenic rituals and various other treatments, the only common

denominators of which are their reassuring, suggestive or mystical dependence of the patient on the therapist. Similarly, if a paralysis or an organic dysfunction responds almost immediately to hypnosis or an injection of Sodium Amytal, or if more resistant dysfunctions improve over a longer period of time as the demonstrable result of more rational, dynamic and lastingly effective methods, the original symptoms may with some reason be presumed to have been of neurotic origin. Such are the criteria useful in the clinical diagnosis of neurotic reactions, whether or not accompanied by symptoms directly attributable to organic disease.

Aside from the physical manifestations of anxiety, sensorimotor, "psychosomatic" or other dysfunctions, there are no pathognomonic physical signs of neuroses. The idea that absent pharyngeal reflexes, increased knee-jerks or other such "hysterical stigmata" are diagnostically significant grew out of confusions as to the nature of neuroses and has long since been abandoned.

In only a few cases, of course, will the initial clinical examination indicate that all of the criteria outlined can be applied, but if one or more are clearly pertinent, neurotic factors in the patient's illness are probable. However, care should be taken not to regard as neurotic any bodily or behavioral dysfunction that fulfills none of the criteria mentioned, even though the patient's illness cannot be explained on purely organic grounds after thorough physical and laboratory investigations.

With this general introduction, we may proceed to examine more closely various clinical syndromes generally regarded as neurotic.

### THE ANXIETY NEUROSES (DSM II, 300.0)

These are characterized primarily by direct manifestation of frank or "free-floating" anxiety. This affect is felt *subjectively* as an unformulated apprehensiveness, ranging in intensity from vague uneasiness to panic, with symptomatic accompaniments of heart consciousness or palpitation, rapid or irregular respiration, constrictive sensations in the chest or throat (*globus hystericus*), flushing, sweating, muscular tension or tremulousness, faintness or mild disturbances of consciousness, and much more rarely, loss of sphincter control. The situations that induce such reactions\* in any particular patient need not, of course, be "objectively" threatening in the

\* Normal or deviant reactions, responses, behavior patterns, adaptive maneuvers and other such terms are used throughout this text in preference to the psychoanalytic concept of "Ego defenses", since the latter implies the mystique of a tripartite Id, Ego and Superego engaged in internecine attacks and counterattacks (see Masserman, *Theories and Therapies in Dynamic Psychiatry*, Science House, 1973).

sense of immediately impending physical harm, but nevertheless, consciously or not, represent or *symbolize* associated dangers in the patient's past and ostensibly "forgotten" experience. Correspondingly, since the patient's reactions are not those evoked by specific fears, direct fight or flight cannot resolve his internalized conflicts. Instead, his responses take neurotic forms, such as spreading inhibitions, phobic aversions, psychophysiological dysfunctions, compulsions and the even more dereistic deviations of behavior described in clinical detail below. When these, too, are transgressed or breached, frank anxiety reappears.

A patient with intense but repressed erotic drives who denies them through profession of a moralistic punctiliousness may experience marked anxiety if directly confronted with sexual temptation; similarly, anxiety may be experienced by a patient who has guarded himself from expressing covert but pervasive hostilities if he is forced to handle lethal instruments during military training. In either case, the patient, though in little or no personal danger, nevertheless senses that he is in a position in which impulsive impulses might occasion acts that, in his experience, had to be repressed on pain of extreme punishment. Under such circumstances, the patient's anxiety persists until he can escape from the situation, master more adequate responses or, either spontaneously or with help, resolve the underlying conflicts between his impulses and his fears.

#### **Differential Diagnosis of Anxiety**

Because of the wide range of physiologic expressions of anxiety, its symptomatology is sometimes confused with that of various organic diseases. Further complications arise when the two exist concurrently, in which case their expressions may be so intimately blended that differential diagnosis becomes a matter of considerable medical as well as psychiatric acumen. A few of the organic conditions from which the anxiety syndrome must be differentiated clinically may be mentioned as follows:

*Hyperthyroidism.* This disorder, too, may be characterized by tachycardia, hyperpnea, sweating, fatigability and muscular tremors and weakness. However, these symptoms are prolonged and progressive rather than episodic, and are accompanied by objective physical signs such as exophthalmos, widening of the palpebral fissure (Stellwag's sign), disturbances in ocular convergence (Möbius' sign), lid-lag or downward movement of the eyes (von Graefe's sign), enlargement of the thyroid, loss of weight and a diminution of blood cholesterol content below 180 mg per 100 cc. It must be noted, however, that other features usually thought to be pathognomonic of hyperthyroidism do not actually furnish infallible differential criteria. For instance, the "basal metabolism" (rate of oxygen consumption during physical rest) is high in thyrotoxicosis, but so also it

may be raised 50 per cent or even more in anxiety states: indeed, it is doubtful that a tense, hyper-alert, anxiety-ridden patient can achieve the state of quiet relaxation postulated as the baseline of the test; in this event, the BMR tracing of the patient's breathing may reveal irregularities, sighing respirations and other arrhythmias indicative of anxiety. Again, the administration of Lugol's solution or thiouracil produces a temporary improvement in certain types of hyperthyroidism, but the nonspecific, reassuring or suggestive effects of any medication (especially barbiturates) may also ameliorate the manifestations of anxiety. Finally, it must be remembered that the thyroid gland is part of the sympathico-adrenal system and is thereby intimately involved in intense affective states. Consequently, a catastrophic reaction or a chronic anxiety may, in susceptible individuals, initiate a reciprocal metabolic imbalance ultimately requiring medical or surgical intervention.

*Cardiac Disease.* Myocardial and valvular disorders can, of course, also be characterized by heart consciousness, flushing, pounding pulse and syncopal attacks; in fact, later stages of heart disease frequently occasion a considerable admixture of anxiety which may complicate the organic symptoms. The differentiation, however, can usually be made on the basis of the relationship of the attacks to physical exertion, signs of cardiac enlargement or decompensation, pathologically significant changes in the electrocardiogram, and the beneficial effects of rest, coronary vasodepressants and digitalis derivatives as distinguished from the purely "psychotherapeutic" aspects of the treatment.

*Hypoglycemia.* Patients with hyperinsulinism ("idiopathic" or resulting from islet cell tumors of the pancreas) may have episodes of hypoglycemia characterized by cold sweats, tremulousness, weakness and profound disturbances of consciousness, sometimes with fugue-like activity. These symptoms usually arise during periods of dietary abstinence; in such cases the patient may have learned that his symptoms are temporarily relieved (often with later exacerbation) by eating sweets or other foods containing easily absorbable sugar. However, hypoglycemic attacks may also occur immediately after meals because of the stimulation of insulin secretion before the blood sugar level can be sufficiently raised by absorption. The differential diagnosis from anxiety attacks is, of course, greatly aided by the finding of a fasting blood sugar below 60 mg per 100 cc, a high sugar-tolerance curve with rapidly diminishing glycemia, a marked hypersensitivity to insulin, and the rapid relief of symptoms after the intramuscular injection of epinephrine or the intravenous administration of dextrose.

*Neurologic Lesions.* Hyperirritability of the carotid sinus, "idiopathic" petit mal, senile, luetic or other diffuse central nervous system

diseases, disturbances of the cerebellum or semicircular canals, and lesions in the vicinity of the diencephalon (sympathetic epilepsy of Temple Fay) give rise to symptoms that may resemble some of those included in the anxiety syndrome. However, the differentiation may be made not only by careful neurologic, serologic and special investigations, but by the general feature that the peripheral symptoms, while sometimes episodic and explosive, are not accompanied by the unmistakable feelings of subjective conflict and apprehension that characterize true anxiety.

*Other Toxic and Organic Disturbances.* Various forms and intensities of anxiety, often complicated by confusion and disorientation, may be caused by caffeine, amphetamine, "psychedelic" (LSD, mescaline or hashish) or acute narcotic intoxications (q.v.), endocrine dyscrasias (especially the "hot flashes" with transient giddiness during the menopause) and other rarer conditions such as Addison's disease and some of the severe anemias.

*"Hysterical Tetany."* A syndrome not infrequently seen is the occurrence of carpopedal spasms associated with attacks of anxiety in patients with disturbed parathyroid, calcium and phosphorus metabolism; in such cases, indeed, the subjective appreciation of anxiety may be minimal, and recurrent tetany under emotional stress may be the only presenting symptom. Generally, however, the diagnosis can be established by studies of the blood chemistry (low ionizable calcium and phosphorus), the presence of jaw-jerk and hyperirritable tendon reflexes, the induction of carpal spasms by the brief application of a tourniquet which cuts off the circulation of an arm (Trousseau sign), and the induction of mild spasms in all extremities by mild hyperventilation.

#### **Nomenclature of the Anxiety Reactions**

The classification of the various "types" of neurotic reactions characterized by overt anxiety is a controversial and often futile procedure, since (a) every shade of intensity from mild uneasiness to panic can occur, (b) the intensity and nature of the anxiety differ greatly with the changing contingencies of stress and resolution of conflict and (c) various modes of mitigating anxiety almost inevitably arise and may soon dominate the clinical picture. If, however, it is understood that the terms currently used to describe relaxed anxiety reactions permit every form of qualitative and quantitative transition, we may differentiate and define the following:

*An anxiety neurosis* refers to the presence of persistent and diffuse anxiety, with recurrent exacerbations under special stress.

*An anxiety state* denotes a more acute and pervasive reaction of tension; restlessness and hyperirritability accompanied by the development of phobias and obsessions.

*Hysterical neurosis* (300.1), has come to have an ambiguous meaning that differs with the connotations of the word "hysteria." Popularly, the term has applied to any state of general emotional excitement, whereas in current psychiatric usage (as derived from Janet and Freud) "hysteria" is applied to "functional" sensorimotor disturbances. Nevertheless, some clinicians use "anxiety hysteria" to designate states of severe agitation up to and including nonpsychotic panics, while others use the same term to signify anxiety with a large admixture of sensorimotor and visceral "conversion" symptomatology. Indeed, as psychiatric terminology has become more accurate and meaningful, the terms "hysteria" and "conversion" may be abandoned (cf. Glossary).

Qualitative and perhaps roughly quantitative statements can be made as to the nature and degree of anxiety and the concurrence of various reactions such as phobias, compulsions or specific psychosomatic dysfunctions. The following case abstracts may indicate more clearly the eclectic and fluid nature of the behavior patterns that may appear.

### Cultural Rituals

Let us first consider a day in the life of a modern urbanite (a preview, as it were, of the "ritualistic personality" described presently under that heading):

**CASE 7. Stereotyped normality (Not listed in DSM II).** Our subject awakens, say, at eight in the morning to the chimes of the town bell—a device modeled far less for sound-producing efficiency than because it has symbolized *pestile-in-fundo* since phallic worship began. He glances at his wife sleeping to his left (so his right arm can be free to ward off inimical spirits) and may remember how only a short while previously he had married her under a canopy (to hide from jealous gods) and had then wondered idly why breaking a glass underfoot (defloration), throwing rice (sowing the field), tying cans to the bridal car (to frighten away demons) and carrying her across the threshold (offering her first to the household god) had been part of the proceedings. But "reality" presses, so he rises from the right side of the bed, puts on his left sock, trouser leg and shoe first and also shaves his face beginning with the left side (for to end with the left is *sinister* and dangerous). At breakfast he may wonder, when he accidentally spills the salt, why he still retains a childish impulse to throw some over his shoulder (to appease the prankish devil obviously present) or to put salt on a bird's tail (birds are souls who may fly away, but can be retained by offerings of a once-precious substance). Breakfast over, he buttons his coat to the right and leaves the building through the arched entrance, closing the door above which his wife may have "modishly" tacked a shining little brass horseshoe (representing the traditional headdress of Isis, moon-goddess of femininity, home and hearth). Once outside, he glances up at the weather-cock (symbol of masculinity), raised as high as possible on the tallest spire in town, and begins to

walk toward his office, buying a newspaper bannered by an eagle (Ra's and Jove's messenger) on the way. The headlines disturb him slightly: the liberal faction (the worshippers of the god Liber-Dionysus who favored free instinctive expression) had lost the election in the national convention of his fraternal organization, so that now the official emblem of the presidency, embroidered with the traditional symbol of the gold star and silver quarter-moon (masculine golden sun in receptive vaginal moon), would cover the midpart of a High Potentate he didn't like. But his reverie is interrupted when he passes the headquarters of the local medical society and sees a more reassuring symbol—either the two-snake sign of Mercury and Apollo, gods of service and medicine or, more properly, the single snake symbol of Aaron, physician to the Hebrews, whose staff created serpents to liberate God's faithful from bondage. Another distraction is furnished by a flower shop which reminds him that next week is Easter (Oestra was goddess of spring and female fecundation) so that he must remember to buy his wife some attractive clothes, an orchid (*orchis* = testicle) and some colored eggs (ovaries) for his children. At the entrance to his office he is beseeched by eager Girl Scouts to buy some doughnuts for their cause and does so (in ancient solicitations, nubile girls offered either themselves or, for a lesser fee, symbolic cakes with a hole in the middle, all proceeds to go to Myletta, goddess of love). Our hero then shakes right hands with a friend (to show that neither carries a weapon), tips his hat to a woman acquaintance (masculine uncovering) and walks into the archway of his office building in common with other "unsuperstitious, sane, civilized, realistic" citizens. Yet, had he neglected any of these "customs," he could have experienced a vague sense of mild to moderate anxiety.

### Cultural Relativity

The behavior patterns here considered, including even more mystic religious practices, can be placed in the context of their ambient culture; however, in variant forms, they may lead to what may be called the *ritualistic personality*—a term applicable to patterns of behavior lying between overstrict adherences to "normal" routines of living and those so deviant or socially maladaptive as to justify the diagnosis of neurosis. Under favorable circumstances, such persons are inclined to be orderly, conservative, ascetic, overly conscientious and meticulous to the point of perfectionism. Under stress, however, they are prone to have ruminative doubts and trepidations, and to become hesitant and indecisive, vacillate between opposite and fleeting decisions and are correspondingly ambivalent in their interpersonal relationships.

CASE 8. *Hysterical neurosis, conversion type (300.13). Dysfunction: military implications.* A 28-year-old man complained that since his service in the Navy two years previously he had suffered from episodes of anxiety described by him as "a stifling in the heart and in my breath and a feeling of being all tensed up and in a cold sweat. I get scared and want to run away from I wouldn't know what or where." The episodes almost invariably occurred when he heard a loud, unexpected

noise, when he was forced to ride upward in a crowded elevator, when he had to wait his turn in a line of people or when he saw a motion picture depicting military maneuvers. He had built up various protective patterns such as avoiding crowds and theaters, walking up stairs whenever he could, insisting on absolute quiet at home, or even wearing cotton in his ears, but these devices on the whole had been ineffectual and his attacks of acute anxiety had continued to be frequent and severe. Moreover, his sleep was increasingly disturbed by a repetitive dream in which he tried desperately to reach the head of a column of people, always failed, and inevitably woke in a state of deep apprehension.

*Physical and laboratory findings* were normal and special examinations showed no evidences of neurologic or endocrine disease, except that the basal metabolic rate was reported as plus 37.

*The past history* of the patient indicated that he had led a somewhat sheltered life, but had made consistent educational and vocational progress and had become a trusted executive in an insurance firm. He had married happily, and had shown no overt neurotic symptoms until the onset of his presenting complaints.

*Present Illness.* At first the patient was vague and evasive as to the circumstances of onset, but after several interviews (one under light Amytal hypnosis), he finally began to trace many of his difficulties to his experiences during naval training. Significantly, he began by recalling only defensive "screen memories," in which the Navy, and not he, was made to appear at fault. As an "economically minded citizen" he had been "outraged" by what he saw of extravagant Navy practice, such as tossing soiled dishes or blankets overboard instead of washing them, reckless waste of food, etc. Gradually, however, as his own guilts became more evident and his anxieties over them more acceptable, the following significant facts emerged.

When the patient was drafted he had chosen the Navy because its training ground was close to his home. He had become resentful and occasionally dejected during the interminable irrational routines of "boot training," but had held up fairly well until he was sent from his base camp to duty in the magazine deck of a destroyer, and placed in a crowded team of men organized to pass ammunition through a mechanical elevator to the gun crews. He experienced considerable fear on initial contact with the imminent dangers of actual warfare, and it was noted that he was always the first to take his assigned place in line at drills for "evacuate post" or "abandon ship." However, he was able to find two sources of security: the generally high morale of the ship and a feeling of personal safety and pride in the smooth efficiency of his ammunition squad. One day, however, one of the most skillful members of his team dropped a live shell on the deck—a harmless occurrence in itself, but one that represented to the patient the possibility of a magazine explosion that would mean certain death. The next day he noted a peculiar stiffness in his right arm and shoulder that interfered increasingly with his work of lifting shells from an ammunition rack to the elevator—a sensorimotor symptom that, apparently, was a neurotic compromise between self-preserved fears and a sense of duty and devotion to his job. The medical officer, noting the muscular tension and the limitations of joint motion in the patient's arm, suspected arthritis and sent the patient to sick bay. Here, two days later, the second and final trauma occurred: the

patient heard that a serious explosion in the magazine of another ship on patrol had killed eight men. His anxiety attacks immediately became more intense and frequent, his nights were tense and sleepless, and he became so susceptible to startle reactions in response to sudden noises or flashes of light that the functional nature of his illness was easily recognized. Unfortunately, no therapy was instituted, and the patient was given a medical discharge. He returned home, where his arm rapidly improved; nevertheless, his anxiety attacks and his symbolic fears of crowds, elevators and war scenes continued almost unabated. One other episode illustrated the semantic spread of these symbolisms: when he returned to work, his employer welcomed him, but explained that since his old associates had been promoted during the wartime expansion of the company, the patient "would have to take his place in line" for his turn at advancement. Although this was what the patient had expected, the phrase "place in line" induced a severe attack of anxiety, followed by uncontrolled sobbing. Similar reactions of anxiety and emotional instability had seriously interfered with his occupational and social readjustments and eventually occasioned admission to the Clinics.

*Therapy.* In brief, this consisted of hospitalization for temporary removal from current stresses and responsibilities, sedation to control insomnia and general tension, and a complete diagnostic checkup to allay the patient's half-wishful "fears" that he was suffering from some serious physical disease instead of a "less serious nervous breakdown." When adequate rapport had been gained, the nature of the patient's conflicts and his various symbolic defenses against pervasive anxiety were traced to his military experience, and preliminary "intellectual" insight was thus established. Concurrently, he was reintroduced into increasingly active and competitive group activities such as card-playing, quoits and baseball. In this way, too, he was induced by the therapist to enter situations he had previously avoided, e.g., a casual ride down and then up the elevator to the playground, passage through the noisy hospital basement, the interpolation of a previously disturbing war picture at an evening's movie show, and so on. Recurrences of mild anxiety during each such experience were interpreted simply and directly in preparation for the next and possibly more difficult one, and in this manner the patient's phobic tendencies were both anticipated and eliminated through preparatory set and subsequent mastery in action (an ancient technique now labeled "behavior therapy," as though to obscure the fact that all therapies deal with behavior).

*Change in Basal Metabolic Rate.* This also showed an interesting reversal: a second test given three weeks after the first showed a metabolic rate of plus 3. Inquiry at this time revealed the cause of the discrepancy in the two BMR readings: the patient recollected that when the mask of the apparatus was fitted to his face for the first time, he had vaguely associated it with a memory of seeing oxygen administered to seriously injured war casualties, and had experienced severe anxiety, which, with some difficulty, he had concealed from the technician at the time. On the second test this reaction was minimal, with a normal metabolic reading as a result.

A few days later the patient left the hospital greatly improved, returned to work, and has since remained symptom-free except for mild startle reactions when exposed to unexpectedly intense sensory stimuli.

*Comment.* The case presents certain almost obvious but highly instructive features. Most prominent is the development of an unconsciously determined motor dysfunction (the arm paralysis) as a temporary adjustment to an otherwise insoluble motivational conflict between need for participation in a group defense (duty) and fear of personal danger. The paralysis temporarily resolved the impasse and provided some escape. However, the patient's fears were again exacerbated by the news of the explosion on a sister ship, after which there was a spread of phobic aversion to various symbols both "objective" and "verbal;" i.e., noises, elevators, crowds, people in line and other such associations reactivated the conflict and again provoked intense anxiety. Fortunately, the patient was able to reexplore his fears under the guidance of a therapist he had learned to trust, and was thus able to reorient his symbolizations, desensitize his reactions and rearrange his patterns of living in accordance with therapeutic techniques that may be simultaneously designated "analytically interpretative," "dynamically re-explorative" or "behaviorally therapeutic." The case also illustrates some of the residual effects of the traumatic or dehumanizing experiences of warfare that affect countless thousands of men long after their acute traumatic experiences in war or elsewhere are ostensibly "forgotten."

### **Obsessive-Compulsive-Phobic Reactions**

An *obsession* is an obtrusive impulse, feeling or thought that persists in consciousness even though it is recognized by the individual as being illogical and morbid (in psychoanalytic terms, "ego-alien"). It is this apparent recognition on the part of the patient of the irrationality of his obsessions that differentiates them from the fixed delusional beliefs of the psychotic—although, as may be expected, all stages of transition between the two can be traced. Mild and transient obsessive phenomena are common, e.g., a haunting melody, a persistent "hunch" or a memory that keeps recurring, despite its apparent irrelevancy to current circumstances. Ranging from such preoccupations to those that are increasingly morbid are *déjà vu* phenomena (odd feelings that a new experience had somehow been lived before), unjustified forebodings as to the safety of oneself or others, or the preemption of consciousness by the pervasive, paralyzing doubts and indecisions of *folie du doute*. Finally, any of these may take on increasingly fantastic, dereistic or paranoid colorings and thus merge into depressive, grandiose or schizoid delusions.

*Phobias* are fears of symbolic situations or acts. Like obsessions, phobias are often recognized by the subject himself, despite attempts to rationalize them, as exaggerated or even unjustified dreads. Yet, because they

are in part an expression of strong unconscious wishes, they are not amenable to the usual forms of reasoning or persuasion. Phobias also are akin to compulsions in that professed attempts to act counter to their supposed dictates give rise to severe anxiety.

There are, obviously, as many varieties and intensities of phobic reactions as there are experiences which may become charged with conflict and anxiety and thereafter directly or symbolically feared and avoided. However, certain clinical types are relatively common, among which are the following:

Fear of crowds (*ochlophobia*) or the close proximity of other individuals. This is often a protection against erotic or aggressive urges that might be awakened under such circumstances. A common variant is street phobias in women, with only partially repressed fantasies of promiscuity or prostitution, which lead the patient to insist, for reasons she cannot logically explain, that some member of her family accompany her wherever she goes.

Excessive aversions to dirt (*mysophobia*), injury (*traumatophobia*), disease (*pathophobia*) or unrelenting dread of death (*thanatophobia*) occur. These are often covert expressions of fears of punishment (guilt) over repressed hostilities toward others and may therefore be accompanied by a reactive oversolicitude for the persons hated. Other defenses against fantasied retributions in such cases are compulsive washing (*ablutomania*), exaggerated precautions against infection or injury, or persistent hypochondriac preoccupations requiring almost continuous medical supervision.

Fear of heights (*acrophobia*) is often elaborated into fear of falling elevators, airplanes, tall buildings, mountain roads, etc. In such phobias, "reaching heights" may be fantastically equated with attaining social, sexual or other successes which would evoke jealousy and punishment from those more powerful than the patient. Such fears, despite their protean forms, are often traceable almost directly to intense familial jealousies and retreats to self-circumscribed passivities. Closely allied to the above are morbid dread of syphilis (*syphilophobia*) or of "insanity" (*psychonophobia*) as the supposedly inevitable consequences of masturbation or other guilt-ridden erotic transgressions. However, in addition to castrative fears so expressed, such preoccupations may also connote other unconscious symbolisms; e.g., that "insanity" signifies a release from responsibilities and inhibitions and, at the same time, is an illness requiring tolerant and forgiving social care. In this sense, many a neurotic patient who expresses intense "fear of being committed" covertly relishes the prospect of a regressive escape to the fantasied haven that an errant but helpless and forgiven child would find in a secure, all-productive hospice.

Obsessive-compulsive-phobic phenomena led Freud to revise the prin-

inciple that all behavior was designed to seek pleasure and avoid pain (*pleasure-pain or hedonic principle*) by adding the concept of "a *repetition-compulsion* based on instinctual activity." In this extension of theory, Freud postulated that traumatic experiences in childhood were thereafter compulsively reenacted and derived their "masochistic" quality from an "instinct toward self-destruction" (*Thanatos*) which opposed the libidinal forces of life and growth (*Eros*). This formulation, however, may be reviewed in relation to the biodynamic functions of compulsive behavior as follows:

*Reexploratory Functions.* A compulsion may represent a restless attempt to reexplore a situation in order to "work through" and dissipate some experiential trauma. An elementary example of this on a semiconscious level is the tendency to keep touching an aching tooth with finger or tongue to see whether the pain is diminishing or at least not increasing in intensity; significantly, if the pain is found to be increasing or excruciating, the process of exploratory testing ceases. So also, with far greater symbolic displacement and almost no conscious control, a soldier with an acute combat neurosis may dream night after night that he is reliving a horrible battle scene, as though by vicarious reexperience he can dissipate his residual anxieties and wake into a relatively safe and reassuring present. Should the conflicts persist, however, other "defenses" (e.g., repression, counterreaction, symptom-formation, etc.) must be utilized to avert either an overwhelming panic or a complete regression to an oblivious stupor.

*Wish-Fulfilling Functions.* A compulsion, like a phobia, may also serve as a symbolically disguised attainment of a repressed desire. Many a mannerism of speech or gesture (e.g., cocking of the head, a mechanical smile, a tic-like wink, an exaggerated accent) unconsciously expresses some highly personalized fantasy of displaced aggression or eroticism, or of wishful identification with some envied figure significant in the patient's development. Similarly, more active and persistent patterns, such as the compulsion to touch or feel objects (*délire du toucher*) or to perform other rituals, may represent a quasi-magical acting-out of primitive impulses continuously to explore and control every portion of the environment.

*Reversing Functions.* Finally, a compulsion may be a symbolic attempt to deny or "undo" a guilt, e.g., Lady Macbeth's tortured attempts to wash the blood of the murdered King Duncan from her hands. And yet in the very act of denial or expiation, the repressed erotic or hostile wishes again appear in newly displaced guise.

Thus, a high school teacher who, for various reasons, hated her work and displaced her hatred onto her pupils, overcompensated for these inadmissible feelings by undeniably conscientious and meticulous attention to her duties. Yet,

while this served to conceal her attitudes from herself and, incidentally, from the school principal, whom she regarded as a tyrannical parent-surrogate, her uncompromisingly rigid perfectionisms also expressed her hostilities against her pupils and more successful fellow-teachers. Both were regarded as rivals for parental favor and treated with a ruthlessness all the more vicious because of the patient's impregnable cloak of prim and self-righteous sacrifice.

Because of such hidden satisfactions and overdeterminations, compulsions, like obsessions and phobias, are readily formed and not easily relinquished, and thereby become an integral part of many neuroses.

### **Repression of Anxiety**

Conversely, should any of these phobic aversions or obsessive-compulsive diversions fail, the anxiety engendered by the original and unresolved conflict immediately reappears. But since severe anxiety is an untenable state of being, the patient must mobilize whatever other denials or adaptations he can muster from his innate capacities, repertoire of experiences and derived verbal or manipulative symbolisms. One type is particularly significant, since it may seem to result in an apparent negation of anxiety with a counterreactive euphoria. The following case is illustrative.

**CASE 9. Counterphobic reaction (300.0).** A young lady came to the psychiatrist from her physician bearing a sealed note which read: "There is something queer about Miss \_\_\_\_\_. She has a blood pressure of 240/142 and has probably been severely hypertensive for a least two years, but she says she has had no symptoms at all. Next week she's to have a complete sympathectomy and she knows it's a fairly dangerous operation with probably a long and uncomfortable convalescence. But that doesn't seem to faze her either. Is she schizophrenic?"

True enough, when the patient—a winsomely attractive girl—was interviewed, she stated at first that, apart from occasional slight headaches, she "felt fine" and if the doctors thought she needed a serious operation, "the thing to do was to have it and not worry about it." Far from schizoid, however, was her sympathetic interest in everything and everyone about her, her facile affective reactions to all topics under discussion other than her own illness, and the friendly rapport she rapidly cultivated with the interviewer. Briefly, her psychiatric history revealed that her parents were cultured, artistic people devoted to their only daughter, that her home life and been relatively happy, and that she had been popular and successful at school and college—far more because of her ingratiating good humor and extroverted activities than her outstanding scholastic abilities. Early in life she had become interested in dramatics, had cultivated her voice under expert tutelage, and had starred in high school and college productions. A talent scout had heard her performance in one of these and had offered her a contract for a minor singing role in a traveling operetta company after her graduation. The patient had been overjoyed, since she considered this as a start on a long-coveted stage career. Cor-

respondingly great, therefore, was her disappointment when a routine physical examination for participation in actors' equity insurance revealed a serious degree of vascular hypertension which made a stage career apparently impossible for her. The patient's reactions to her disappointment were characteristic: she denied the seriousness of her illness to herself as well as to others, trustingly put herself into the hands of her physicians, and blithely planned to fulfill her contract after the "slight delay" of her operation. The defensive nature of this behavior, however, became apparent when the patient later confided that she had really been suffering from headaches, tinnitus, vertigo, fatigue and other symptoms for several years, had wished to seek help, but had feared to do so because a serious disorder might be diagnosed. Finally, she confessed, with what was now an unconvincing attempt at nonchalance, that if through some inconceivable chance she could not continue her dramatic career, she would hardly consider life really worth living and suicide would be the only solution.

Here, then, was an individual whose denials of symptoms was a compulsive device designed to mitigate otherwise catastrophic anxiety. By this defense she had kept herself tolerably cheerful, active and socially useful but, unfortunately, at the expense of neglecting the premonitory signs of a dangerous illness. The unusual, yet significant, feature of this case was the persistence of this denial of anxiety up to the moment of the psychiatric interview.

*Course.* Under sympathetic encouragement the patient was able to confess almost to the full her doubts and trepidations during the course of several interviews. Some of these were characterized by marked emotional "catharsis," including tears and protestations of hopelessness and discouragement, yet each such affective discharge, since it evoked understanding acceptance and reassurances, left the patient quieter and more receptive to realistic orientations. Finally, when she changed her attitude from a brittle, anxiety-ridden pretense of unconcern to a more confident and stable courage, a Smithwick sympathectomy—an operation popular at the time, but now rarely done—was planned and performed. She cooperated well in preoperative and convalescent therapy, and left the hospital with a relatively well adjusted acceptance not only of her physical limitations but also of her remaining capacities for creative and relatively happy living.

### **The Ritualistic Personality**

This designation may be used to describe a character-formation lying between a somewhat overstrict adherence to the "normal" routines of living just described (and cf. Case 7) and those so deviant and socially maladaptive as to justify the term "neurotic". Under favorable circumstances such persons are inclined to be orderly, conservative, ascetic, overconscientious and meticulous to the point of perfectionism. Under stress, they are prone to have ruminative doubts and trepidations, and to become hestitant, indecisive, vacillatory among opposite and fleeting decisions and correspondingly ambivalent in their interpersonal relationships.

These characteristics, when combined with superior intelligence, may

qualify the individual for certain special pursuits (e.g., bookkeeper, computer programmer, brief lawyer) that require unremitting attention to detail, self-critical exactness and plodding persistence. Unfortunately, however, such persons, despite a carefully stocked and indexed memory and manner of reserved profundity, are not usually fitted for imaginative research, inspiring teaching or creative accomplishment. Moreover, should their accustomed routines fail them, a restless anxiety appears which requires the formation of new and more elaborate rituals until, finally, the obsessive-compulsive reaction becomes excessively rigid and manifestly deviant. Even then the patient, though he may profess eager willingness and actually abide by all external requirements of the therapy, often shows intense resistance to change. Moreover, since he usually lacks friends and may already have alienated his family, other interpersonal and environmental influences are not readily available. Despite the prominence of obsessive-compulsive features in our culture (Case 7), from an etiologic and prognostic standpoing "normal" rituals that become progressively intractable may be transitional to a psychosis.

The following case history illustrates a transition to more symbolically disruptive phobias, obsessions and compulsions.

**CASE 10. *Anxiety reaction with zoophobia (300.2).*** A 19-year-old girl was brought to the Clinics with but one presenting complaint: a "fear of dogs" of such intensity that she repeatedly searched her home to make sure that no dog was there, and had refused to visit elsewhere for weeks because of the possibility of encountering a dog in some other home. Direct inquiry, however, revealed that this was not absolute cynophobia; for instance, she was not afraid of dogs on the street, but only that she might encounter them in houses; even there, she feared no physical injury; yet experienced the physiologic manifestations of anxiety.

The medical diagnostic examination was noncontributory and the Binet test confirmed the impression of normal intelligence. However, the psychiatric history, which was obtained with very little difficulty because of the patient's passive and naively dependent transferences to the therapist, revealed certain behavior patterns which could be traced dynamically as follows:

The patient's mother was a severely disturbed woman who, because of her own repressed extramarital fantasies, was continually suspicious that her colorless, innocuous husband was unfaithful to her. In reaction she had for years made his life miserable by her perfectionistic cleanliness, insistence on extreme orderliness in the household and multiple other compulsions with which she forced the family to comply. The patient had been raised with the same covertly aggressive oversolicitude but had become excessively dependent on the mother, inclined to identify with her and to adopt similar neurotic patterns.

When the patient was eight, a younger brother was born, who immediately became the family favorite. As soon as the baby displaced her from the parents' bedroom, the patient began to have night terrors and shortly thereafter developed

her first phobic and compulsive reactions. One pattern particularly well remembered was the urge to burn the baby's sheets, diapers and toys. Significantly, this obsession, according to the patient's own memory, was "cured" when an aunt upon whom she centered her yearning for renewed affection gave her an expensive bracelet and told her "to look at it and remember me every time you feel like burning something." Other mild phobias and obsessive-compulsive patterns appeared throughout adolescence, but the patient was able to complete business school and to work in an office for several years before her "breakdown." However, her repressed but intense rivalry with her brother persisted and, about a year before her admission to the Clinics, became focused on his insistence that he be allowed to keep a male puppy as a pet. The patient argued against her brother's demands on various rationalized grounds such as that the dog, which the patient apparently equated with yet another unwanted rival, would bring "dirt and disease" into the home, but she finally tolerated the animal after exacting a solemn promise from her parents that her brother was to be given no further concessions. Two months later the brother succeeded in getting the parents to accept a puppy "to keep the other dog company," and it was then that the patient's objections became so violent that both dogs had to be removed. The damage, however, had already been done: the patient became so obsessed with the idea that during her absence a dog might be allowed to enter the home that she refused to leave the house for work or any other purpose, developed a ritual of searching the basement thrice daily, and even retired to her bedroom to avoid speaking to visitors who had professed a liking for the dogs. During this period other neurotic reactions developed which indicated that her phobic aversion to her brother's pet was also determined by unconscious incestuous attachments to him. For instance, she became extremely guilty about masturbation because she fantasied her brother's nude image during the act. As a defense against this, she began to make serious plans for an immediate marriage to a man she had known only a few weeks and who, in reality, had no matrimonial intentions whatever. In another compulsive effort to tear herself away from her conflictual familial ties, she applied to her physician for an examination preliminary to service in the Women's Army Corps. The physician apparently considered the patient psychotic, despite the lack of fixed mood disturbances, overtly delusional content, fixed regressions, etc., and referred her to a sanatorium, where her sole therapy consisted of four inhalation treatments with Indoklon and one electroshock convulsion. These had no beneficial effects but, fortunately, the patient was so grateful for any type of care that her capacity for cooperation in further treatment was not seriously impaired when she was finally referred to the Psychiatric Service.

*Therapy.* This consisted in an initial expenditure of considerable time and energy in examinations and tests, followed by informal interviews directed toward cultivating a feeling in the patient that the therapist was a kindly and trustworthy parent-surrogate thoroughly interested in her welfare. Once this attitude was tentatively established, the patient quite readily revealed the origins of her anxieties and her phobic and compulsive defenses, and even in the telling gained some superficial "insight" into the experiential determinants of her behavior. As her dependence on her parents diminished, the therapeutic transference was utilized to establish progressively more stable patterns of reorientation. For instance, the patient was in-

duced to visit the hospital animal quarters with a motherly nurse delegated by the psychiatrist; next, she was casually assigned to stuff toy animals in occupational therapy, and eventually even visited the therapist's own laboratory and petted his dogs with little or no reaction of anxiety. Concurrently, she revised her unrealistic "plans" for immediate marriage or Army service and agreed instead to return to her home and her job. As expected, she at first found it necessary to visit the psychiatrist at weekly intervals with new complaints, the content of which continued to be naive and directly symbolic. For instance, she protested that "mother's canary keeps me awake nights," or that she had become angry because her father had bought ice-cream cones for the neighbor's children "who would get spoiled if he did that." Gradually, however, these visits became less necessary and frequent, and the patient, two years after her discharge, was free of disabling symptoms, was working steadily and, though neither mature nor completely emancipated, had cultivated fairly satisfactory extrafamilial interests, contacts and relationships.

*Comment.* If we neglect for the moment the many ancillary dynamisms operative in this girl's neurotic behavior, it is apparent that her primary motivational conflict lay in her dependence on her parents as opposed to her ambivalently jealous attitudes toward her brother. Because of his position in the family hierarchy, she could not openly antagonize him, but she displaced her anxiety-ridden aversions onto sibling surrogates such as dogs and canaries and regressed into a childlike dependence on her parents, while at the same time making them suffer for their fancied rejection of her. In therapy, advantage was taken of the ease that the patient had previously displayed in transferring her dependency needs to anyone who would give her security for the moment. The therapist thereby assumed the role of the parent and helped mitigate her anxiety in the protected environment. After this, he could guide her in extramural adjustments and, finally, into more generalized and emancipated interpersonal relationships outside her immediate family circle.

#### **Counteraggressive Anxiety**

As we have seen, any strong motivation that threatens to break through counterposed fears and inhibitions gives rise to anxiety. Thus, the anxiety of the adolescent threatened by forbidden sexual temptations is still surprisingly prevalent in our culture and is often expressed in dread of the supposed effects of masturbation—an act charged since childhood with incestuous fantasies and fears, and thereby punishable by symbolically castrative retributions such as "loss of manhood," "consumption" or "insanity." An even more incisive form of anxiety is one that warns against a welling-up of repressed aggressions which threaten to break their bounds. This type of anxiety is very commonly experienced by soldiers who, for the

first time in their lives, are trained in the use of lethal weapons for the express purpose of homicide. Under such circumstances, they may develop an overcompensatory loyalty to the "buddies" in their "outfit" as distinguished from a fantastically depersonalized or brutalized hostility to "the enemy." Unfortunately, in nonmilitary situations this type of defense is not readily available, and in such cases the anxiety may reach great intensity. One exemplification of this became so common among workers given charge of potentially destructive machines during the early expansion of war plants that for a time their term "crane neurosis" had a nosologic meaning of its own. An interesting example is the following:

*CASE 11. Obsessive-compulsive neurosis with homicidal preoccupations (300.3).* A 22-year-old laborer complained of typical and severe anxiety attacks that had begun two months previously, and which he attributed to "heart disease from overwork." The history revealed that he had been raised amid privation in the slums of a steel town, had received relatively little formal education, and had grown up with strong resentments against an economic system that, he felt, sentenced him to a life of squalor and drudgery. These resentments had been intensified by his first years of work in the steel mills until, seeking support for his social hostilities, he joined a radical political group pledged to a program of violent revolution. In accordance with the party plan, he was assigned to remain and, if possible, advance himself in the steel mill so that he "could work and then strike from inside." When the war came, however, circumstances changed rapidly and in a way that made the patient's attitudes toward his job and his employers considerably more ambivalent. Because of his skill and intelligence, he was promoted to profitable work amid favorable surroundings, and when he again proved his competence, he was classified as an "essential laborer" and so saved from dreaded military service. Finally, he was given the best-paying and most responsible job available at his level of employment—operating a huge crane that transferred iron ore from a lake freighter to an open-hearth furnace. The patient gloried in this work so long as his instructor was with him to prevent any mistakes in operation. However, The first day he was trusted alone in the control turret he began to experience severe anxiety, which soon centered about a single obsessional thought; namely, that with one pull of a lever he could so manipulate his gargantuan machine as to wreck the dock, sink the ship and probably kill several men. As he pictured this his heart pounded, his hand trembled, his vision blurred and his knees grew weak; finally these subjective and physiologic manifestations of his anxiety grew so severe that he applied for sick leave and entered the Clinics.

*Therapy.* This consisted of protective rest, sedation and a thorough physical examination, conducted mainly so that complete reports as to the patient's physical health could be sent to his employers. With sympathetic understanding and guidance, the patient, an intelligent and essentially honest individual, readily recognized that his persistent fears had their origin in conflicts between his lifelong aggressions, counterpoised inhibitions and recently altered group loyalties. As insight deepened and new securities in therapeutic and social relationships were

found, his obsessive anxieties diminished rapidly. Fortunately, too, his aggressivity was further disarmed when the company he had worked for proved entirely cooperative in paying his hospital fees, giving him an interim vacation and then offering him a choice of employment. The patient returned to work, found his duties as a ground-gang foreman almost entirely to his liking and has remained symptom-free.

#### **Variant Dynamics in Anxiety (300.4,5)**

Other forms of reaction to latent anxiety are sufficiently common in clinical experience to deserve specific mention. A relatively frequent variant is the so-called "anxiety of success," which occurs in individuals troubled by such deep feelings of inadequacy or by unconsciously ingrained fears that even minor advancements make them apprehensive of eventual downfall. In such persons, promotions or other ostensibly desirable attainments, deserved or undeserved, lead to what appears to be highly irrational reactions of trepidation and depression. Another form which even more directly approaches literal "castration anxiety" occurs in individuals who anticipate that any display of exhibitionistic, erotic or aggressive activity, however indirect, will somehow lead to ridicule, rejection or injury, ranging from the difficulties some men experience in urinating in a public toilet, to pervasive fears of dentists, surgeons or even barbers who wield cutting or deforming instruments. "Emancipation anxiety" appears in individuals who, after leading sheltered, dependent lives, attempt too rapid a transition to work, marriage, childbearing or other relatively mature and self-reliant pursuits. Such anxiety may be particularly marked in bridal couples or young parents who find their new status less a sinecure than an unexpected responsibility. Another form, relatively common in military life, arises from repressed homosexual tendencies which themselves may be escapes from the supposed responsibilities or dangers of heterosexuality. This type of anxiety is frequently precipitated when a person of either sex with previously adequate homoerotic defenses is forced into intimate proximity with, or is promoted to a position of authority over, other individuals of the same sex. Under such circumstances there may be a flight into excessive heterosexual activity or other overcompensations; however, if these fail, "homosexual panics" with violently aggressive or suicidal behavior may occur.

#### **Depersonalization Neuroses (300.6)**

Cataclysmic disorganizations of behavior—so severe that they transcend and are usually classified apart from other anxiety syndromes—may occur in reaction to sudden catastrophes or under a sharp crescendo of

stress which rapidly exceeds the patient's capacity for adaptation. Many "acute war neuroses" after physical or emotional battle traumata fall into this category, as do states of extreme exhaustion or *shock* seen after civilian catastrophes such as train wrecks, fires or earthquakes. Indeed, *shock* in the surgical sense of vagosympathetic atonia may be manifested in vascular hypotension, lowered body temperature or poikilothermia, thready pulse, loss of sphincter control and other ominous signs of neurophysiologic collapse. In reactions less severe than these there may be disorientation, amnesia, aphonia, excruciating hypersensitivity to sensory stimuli and extreme restlessness or fugue-like motor activity. Such reactions are often of adverse prognostic import, since even if the severe physiologic exhaustion is adequately combated by rest, warmth, fluids, stimulants and other supportive measures, the experience may leave lifelong neurotic residue in susceptible individuals. It is almost equally important, therefore, that adequate psychiatric and rehabilitative therapy be instituted before excessive anxieties, phobias, regressions or other neurotic patterns become fixated. Sometimes hypnoanalysis, narcosynthesis or other special methods are indicated, but ordinarily, an eclectic approach as described below may be effective:

**CASE 12. *Brief therapy of severe obsessive-compulsive-phobic reactions.*** For about five years, a 27-year old girl had developed rigid and increasingly pervasive compulsions with regard to cleanliness, dress and diet that had finally made most of her waking hours a succession of imperative rituals. These included such severe phobias of closed spaces, heights, the dark and of being alone on the street that in the twenty months preceding her admission to the clinics she had refused to leave her home unescorted. The patient had a ready explanation for some of her behavior. Just preceding their onset she had been followed home from work by a Negro who, she thought, "wanted to attack me." She remembered experiencing fear mounting to panic *the closer to home she came*. After this episode, she had become subject to severe anxiety at theaters, dances, picnics and in a rapidly increasing number of other situations. While she admitted that some of her compulsions in hygiene and dress were not altogether justified, she defended most of them on the grounds that she had been raised by her foster-mother to be "neat," "clean" and "modest," and accordingly had developed fixed "habits" in these respects.

The girl proved to be of unusually high intelligence (I.Q. 142) and, despite her initial ambivalence and reserve, rapidly established a good working rapport with the therapist. A fairly rich psychiatric history was then obtained, which can be summarized as follows.

Her own parents had died when she was 8 years old and she had been raised since then by a married but childless aunt. The patient described this aunt as a forceful, self-reliant, successful "professional woman"—a hospital head nurse—who had provided the patient with a secure home and every material need, but who had been precise and undemonstrative and had insisted on strict obedience and primly

disciplined behavior in every respect. In her quest for affection the patient had turned to her uncle, who also felt frustrated by his self-sufficient and frigid wife. The uncle had responded warmly, and soon became the girl's confidant and companion. However, the aunt became increasingly jealous of this attachment between her husband and niece and, after the patient's menarche, had apparently begun to suspect that there was a growing erotic factor in the relationship. Accordingly, she had begun to lecture her ward on the "filthiness of sex," on the "black and benighted character of men's carnal desires" and on the necessity for continual wariness as well as righteousness on the part of all girls who would "avoid the consequences of carelessness or folly" in such matters. Concurrently, discipline of the patient became even more strict with regard to dress, habits and demeanor until the patient herself, necessarily repressing her resentments for the sake of security, had adopted fixed rituals and persisted in them even when not under the aunt's direct supervision. Her sexual repressions became especially stringent and were manifested in an extreme modesty of dress and stilted formality of manner that further handicapped her popularity at school and her opportunities for extrafamilial activities. At college the pattern was repeated: her intelligence and perfectionistic study habits again brought her high scholastic honors, whereas her now firmly ingrained inhibitions and social idiosyncrasies prejudiced any attempt at emancipatory extracurricular and social activities.

When the patient was 19, a major crisis in her life occurred: both foster-parents were killed in an automobile accident. This event precipitated a period of listless depression, in which, significantly, the patient could not rid herself of the obsessive idea that she had somehow been responsible for the accident, and particularly for the death of her aunt. So disturbing was this thought that she abandoned school, made no effort to share in her aunt's estate, went to live with another relative and soon afterward took a routine, underpaid job as a government secretary. She continued to be exact but inefficiently slow in her work and inhibited in her social relations, although apparently she had no serious difficulties until the threatened "attack" by the Negro. After this, however, frank episodes of anxiety appeared, and her phobias, obsessions and compulsions increased rapidly as recounted above.

*Therapy.* At first, the patient was permitted to indulge all of her idiosyncrasies in the ward: wearing voluminously concealing pajamas and robes even in bed, remaining isolated in her room, rinsing each dish before eating from it, washing her hands every half-hour, and so on. No immediate attempt was made to investigate or interpret these patterns but, as rapport was gained in succeeding interviews, it was noteworthy that the patient herself began to recognize the meanings of some of them and to discontinue others spontaneously. For instance, she began to correlate her fear of dirt with her extreme inhibitions "about dirty sexual thoughts," and finally began to recognize and confess that she had felt these inhibitions to be necessary not only because they had been ingrained by severe training but because they were counterreactions to her own erotic wishes. These she continued for a time to characterize merely as "filthy ideas," but gradually she added more specific content. For instance, she recollected that during high school she had attempted digital masturbation, had suffered reactions of severe guilt and had been so obsessed with the idea that her hands smelled of vaginal secretion that she had

developed "a habit of washing them before touching anything anyone else might touch." In this connection, too, she hinted that the very act of rubbing her hands in thick soap was in some respects itself a symbolic form of displaced masturbation. Similarly, she admitted that her anxiety during the episode of the Negro was less a fear of injury than a horrified fascination with the idea of a forced intercourse for which she could not be held responsible, and a growing impulse to permit herself to be "raped by a black man in the dirty alley right by my aunt's house—so the closer I got there *the more afraid of my aunt I became.*"

The patient was, of course, amazed that such confessions were anticipated and taken as a matter of course, and for a time could not accept the therapist's assurances that they did not indicate her complete depravity. Nevertheless, in the security of the therapeutic situation, the patient's tolerance to reorientation gradually increased, and as her anxieties and guilts diminished her transference needs became more spontaneous, explicit and therapeutically useful. For instance, the patient began to envy the "privileges" other patients were granted by the therapist, such as coming to his office for interviews, being permitted to take walks outside the hospital, eating in a common dining-room, etc. Accordingly, she began to emulate these activities, first with the companionship of a nurse, and eventually alone; indeed, within two weeks after her admission the patient was attending the theater on "afternoons off" from the hospital. At this point, moreover, her energies could be turned into constructive and rehabilitative channels. She was asked to volunteer part-time services as an aide in one of the clinical laboratories of the hospital. As was anticipated, her previous "fears" of excreta also had their strongly attractive aspects and the patient became highly intrigued with the technique of urinalysis, blood counts and other such symbolically scatologic or voyeuristic pursuits; moreover, because of her intelligence and precision, she rapidly proved herself to be a valuable assistant. Plans were therefore worked out for her to take up this training professionally, and the patient, while still hospitalized, was sent to a downtown laboratory to apply as student helper—a position which she secured almost entirely on her own initiative. During the fourth and last week of her hospitalization, she was seen frequently by a social worker, whose offers to aid and accompany her in finding social and recreational outlets were accepted and utilized. In this way, the momentum of the patient's recovery was carried over after her discharge from the hospital, and she not only began to work at an interesting and promising career, but also expanded her social contacts through the medium of Y.W.C.A. activities, volunteer Red Cross work, study clubs, etc. Her readaptations were at first guided by interviews every few weeks with the psychiatrist and social worker, but within a year these seemed no longer necessary. At a follow-up interview three years after her discharge the patient reported that she had completed her training, received a technician's certificate, and was steadily employed in a hospital laboratory. She still had some tendencies toward compulsive orderliness of habits, but her disruptive phobias, obsessions and compulsions had almost completely disappeared. She had cultivated friends and recreational interests, had become engaged to a man after a mutually satisfying sexual liaison with him, and she anticipated with pleasure their marriage on his return from service overseas.

*Comment.* For the sake of accuracy it may be well to point out that the dynamisms of the patient's recovery were not as rationalistic as appeared on the surface. Various dream-associations and other material indicated that the therapy had in large part been effective because the patient had formed a pseudo-avuncular transference to the therapist, and that in this relationship she had recapitulated various childhood rivalries and identifications in emulating the patterns of the other patients. Finally, in adopting the work of a laboratory technician, the patient had not only acted out the obverse of her "fears of dirt," but had unconsciously identified herself with the professional standing of her aunt under the aegis of a more permissive aunt-surrogate, the social worker. When this identification was not only permitted but encouraged in the therapy, she could express her previously repressed erotic and other drives with markedly decreased anxiety—although, of course, in a relatively sublimated and socially acceptable fashion. In this sense, the patient was still potentially "neurotic"—and yet this very utilization of neurotic dynamisms for desirable personal and social reorientations represents a therapeutic artifice useful in many modes of therapy to produce the desired effects.

#### **GENERAL PROGNOSIS IN ANXIETY NEUROSES**

Unfortunately, the therapeutic results in the patient just cited are not representative of what may be expected in even more severe and longstanding obsessive-compulsive character neuroses, which are among the most difficult and disappointing of therapeutic problems for the following reasons: (1) the acute presenting symptoms for which the patient seeks therapy are usually but extensions of fixed and firmly rooted character traits; (2) these traits in turn represent modes of adaptation that give the patient many covert gratifications; (3) any change in the fixed patterning of the patient's behavior is therefore strongly resisted by the patient, and (4) an effective therapeutic transference may be difficult to establish because of the patient's pervasive ambivalence. However, if the patient has previously shown spontaneity, resiliency and versatility of adaptation and exhibits such responses to therapy, the prognosis is correspondingly improved.

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## Chapter 4

### DREAMS IN DIAGNOSIS AND THERAPY

According to Freud, dreams have the following features: the *manifest content*, comprising the setting, characters and story of the dream; the *dream symbolism*, common in the culture but in some part unique to the dreamer, and the *latent content*, or unconscious meanings intended by the dreamer. The dream also has *reference* to the reality of recent occurrences (*waking residue*), to the patient's repressed or marginally recallable past (unconscious or preconscious memories) and to the current status of his therapy (*transference* and *insight*). By combining all of these data with the patient's own associations to parts of his dream, the analyst can understand the dream's meaning, whether or not he interprets this to the patient at the time—considerations that hold true for *any* form of communication for the patient. In reality, however, the therapist can never really know what the patient actually "dreamt"—all the therapist can deal with is the patient's highly selective account of his memories of a succession of images he had retained on waking as further modified by a host of influences preceding the telling. Fortunately, these modifications also have diagnostic significance.

Another difficulty is that some patients, given an explicit choice to talk about their dreams, their past, their analyst or current reality, choose to do so in precisely that descending order of preference, since dreams are the farthest removed from real relationships and can be used to seduce the unwary therapist into endless and largely futile interchanges of vague symbolisms. This serious error of technique can be guarded against in a number of ways, mostly by negating what is advocated in some psychiatric dream books: i.e., (a) by *not* overstressing the importance of dreams in the preliminary explanation of therapy; (b) by *not* directing the patient specifically to record his dreams immediately upon waking or to take pains to remember them in exact detail\*; (c) by *not* inquiring routinely in any lull of communication if the patient "had had any dreams lately"; (d) by *not* spending the interview in minute "associations" to various parts of the dream until the patient produces one that satisfies the therapist; (e) by *not*

\* Chinese devotees of Lao-tse love the legend of Chuang-tze, who dreamed he was a butterfly and ever thereafter suspected he might be a butterfly dreaming it was a man.

remarking, "It seems that we have not as yet fully analyzed the dream; shall we continue next time?"; (f) by *not* letting all this lead up to some routine interpretation such as, "This dream is predominantly anal-erotic," or "It obviously represents a death wish." Such statements will suit the patient because, having brought "interesting" dream material which obviously pleased the therapist, the patient can relax with a glow of accomplishment and with no further immediate necessity either to comprehend or change his other behavior.\* True, every one of the steps here proscribed may be indicated in special circumstances, but consistent transgressions of too many of them will induce the patient to bring a plethora of long, involved, diverse dreams which, as Freud himself warned, should be interpreted principally as designed to postpone realistic understanding and progress. Properly handled, however, dreams can still be meaningfully utilized diagnostically, for example as follows:

**CASE 13. *Demonstration of Covert Wishes.*** A young, recently married girl, who was brought to therapy by her husband because of frigidity and episodes of melancholy, discussed the following dream in her third interview:

"Mother was in bed with me. You visited my husband and did all the talking for an hour. Then you and I went for a walk and you said I should be close to mother. Then mother called me long-distance and asked how I was getting along and I said all right. She said she would come to stay with us."

This dream is a fair example of the relatively naive and direct expression of wishes that occurs in children and in patients either early in therapy before their evasions are mobilized or near the end when insight has been gained. Such dreams hardly need "interpretations" in the sense of divining their meaning; the skill in handling them consists in not pressing *all* of their significance prematurely on the patient. In this instance, without asking for associations or for a repetition of the dream (sometimes done to note omissions, changes or elaborations on second telling), the therapist gently pointed out to the patient the wishes she had sincerely denied having in previous interviews but had confessed in her dream; namely, that she be a little girl again in bed with her mother, that I do all the talking in interviews instead of her being required to do so, that her husband be treated and not she, that our relationships be casual and friendly rather than professional, and that her mother continue her interest in her and, indeed, come to live with her again. To all of this the patient agreed, and with my promise that I "would *not* tell her husband," she informed me further that she was neglecting the home and denying her husband sexual satisfactions because the only time she had broached the subject of her mother's coming to live with them he had been adamant in refusing his permission. Later in therapy the less obvious meanings in her dream were also recalled and utilized: her mother's quasi-sexual seductions when, during the patient's adolescence, they had slept together; having me come to their home as a maternal figure to lecture her husband; "taking a walk" as a figure of speech she and her

\* James Joyce referred to this as the "Intrepitation of dreams."

husband had used a catch-word for getting away from her mother's home to have intercourse; my then playing the husband's marital role but telling her she should love her mother also, and so on. Had all of the meanings been crowded on the patient at once, confusion and resentment would have obscured partial insight and progressive understanding.

*Wish-fulfillments* in dreams may take on far deeper regressive colorings than return to a merely adolescent premarital existence:

CASE 14. *Regressions.* A successful but tired and harried physician expressed his desire to renounce the trappings of manhood and revert to the oral autisms of his covertly envied infant son, in this relatively simple dream:

"I plucked off my penis and sucked it, without ejaculation or orgasm."

To this he associated: "My son peacefully sucks his thumb, and it infuriates me."

For that matter, quasi-intrauterine fantasies are not infrequent, viz: "I'm in a small, quiet room that seems to be a combination of grocery store and hotel. I'm supposed to go outdoors but I don't want to."

Even in instances as frank as these, the dreams should not be discussed in technicalities such as "self-castration" or "Nirvana-fantasies," but in terms of wishing to return to infantile irresponsibilities and dependencies or to escape from the world altogether.

*Dream Symbolism.* This is sufficiently unique for every person so that no direct translations are ever permissible: e.g., a "tower" or an "elevator" does not always represent the penis; both, in one patient's inner language, represented the therapist who "tows" the patient along or "elevates" his mood. Similarly, an arch is not always equated with the vagina in any simple sense; instead a patient associated the symbol with the Arc de Triomphe, representing a grandiose passage into nowhere in particular. So also, a cave need not represent a womb; in one instance it was a term of despair—"all my hopes caved in." If a sensitive ear is kept attuned to the patient's meanings rather than to the therapist's preconceptions, a rich store of information can be secured.

CASE 15. *Aggression.* A former official of the Office of Civilian Defense reported the following dream:

"Everybody in New England felt threatened because Russia had declared war. There were bombers over New York, and the President and the Secretary of Health, Education and Welfare and I were fleeing to the Olympian Peninsula."

At first hearing, this dream seemed a simple expression of his unresolved rancor at having been dismissed from this government post: he pictured a tragic failure of the Defense Department without him, with punishment of the highest authorities and their reduction to his own status. And, since all fantasies, dreams and other communications are *overdetermined*—i.e., expressive not of a single meaning,

but a rich and complex aggregation of many—this connotation of the dream, too, was relevant. But why the special references to New England and New York, the “Olympian Peninsula” and, for that matter, the Secretary of Health, Education and Welfare? Here the patient’s own associations gave the relevant clues as follows:

*New England:* Boston was the American Athens of refinement and culture, and the patient had always been proud of belonging to a Boston Brahmin lineage related to one of the Presidents of the United States.

*New York:* His fiancée belonged to a commercially powerful New York family, into which his parents were urging him to marry for the sake of an assured future in the legal profession.

*Bombs over New York:* He had flown there for a weekend with his fiancée, Rebecca, and had had intercourse with her. She had described her orgasm as a “bomb,” and had said and done other things that he considered juvenile and uncouth. He disliked her restless hyperactivity—a characteristic that had earned her the unlovely nickname of “Rushin’ Reba.” He himself enjoyed their sexual relations only moderately, but frankly disliked the prospect of their married life together.

*The President:* Again, his famous ancestors. He could not understand why his parents, in a family as proud and close-knit as his, would want to barter the prestige of their name merely for the money and position to be obtained by this marriage.

*The Secretary:* It was his mother who had always looked after his health and education, and she, too, had now turned on him. In fact, she was the one who had urged the trip to New York in the hope that a marriage date would be set.

*Olympian Peninsula:* Mount Olympus, where the Greek gods resided. They had “lots of sex but didn’t marry.” The place where salmon came to breed and die, just out of blind instinct.

Here, then, quite another configuration of dream wishes, actions and solutions was manifest. In effect, the patient considered his prospective marriage in New York no less a threat than a Russian (Rushin’ Reba) declaration of war, to be implemented with bombs (preemptive orgasms). He wanted New York and its inhabitants destroyed, while he rejoined his elite father (the scion of presidents) and his mother (like Mrs. Hobby, then matronly Supervisor of [his] Health and Education) on Olympus. True, some lowly creatures of instinct breed and die, but not gods like himself. As may be anticipated, the fixations and compensatory grandiosities revealed in this dream required prolonged analysis, even when this was considerably expedited by covert communications such as those outlined above.

*Anxieties and Fears.* These are frequently expressed in dreams with symbolic frankness long before they are verbalized in conscious complaints and associations. Examples are the following:

CASE 16. *Psychosomatic Dependence.* A young accountant had led a protected existence until the age of 22, when he married a dependent, rather incompetent girl. Soon afterward he began having symptoms of peptic ulcer, which were exacerbated a few months before his therapy by a series of failures in competing with rival

newcomers in his firm. He anticipated his later intense anxieties over the possibility that his wife was pregnant in the following dream:

"Lice were eating our house plant, and I sprayed and killed them."

His spontaneous associations were, "The plant was one mother gave us for our anniversary. Lice-mice. I'm afraid of mice; they used to get into the candy mother gave me. I'm sending my wife to a gynecologist; hope he gives her a douche to clean her out. If I ever have a son, I hope I don't mistreat him like I did my baby brother."

CASE 17. *Quasi-castration*. Another one-line dream was that of a naively literal-minded professional wrestler who had developed an aversion to his trade after consulting a physician for an insurance examination. The dream was as follows:

"I had a pimple down there [indicating his groin] and stuff came out and it left a cavity like an abscess or something, but I felt fine."

At first he insisted that, although the dream had remained vivid in his memory for two days, it had meant nothing whatever to him. Then he recalled that his sister had been ill for several months with an abscess. Asked why he had pictured himself like his sister, he professed not to understand, then inquired suddenly, "Hey, doc, what does 'latent' really mean? It's a queer word. I looked it up but I couldn't get it." Asked tactfully, "Latent what?" he replied "Queer." Asked again "Queer how?" he burst out unexpectedly: "That young punk—excuse me, doc—I mean the guy who did my last insurance exam said wrestlers are latent homosexuals or something. That means queer, don't it? Felt like bopping him one, but he was a little guy. It ain't like that, is it, doc? It's had me worried, me married with two kids and all."

The dream, it was true, was a crude expression of bisexuality and of identification with his sister; moreover, if the physician had not touched on a sensitive spot he would have been in no danger of being "bopped." However, "latent homosexuality" is a term about as useful as latent aggression, and in most cases about as meaningless. The burly athlete, to the therapist's knowledge, had a physique, income and family life that compared favorably with those of the physician who had examined him; certainly, he had had no previous sexual or other serious adaptational difficulties, and was unlikely to have any in the absence of further iatrogenic traumata. Ergo, as seemed best, I assured the patient of his normality, explained that latent meant "*not* active," as he could confirm in any dictionary, and that the physician had thus signified that the patient was *not* "queer." The patient went forth to wrestle with more realistic problems, which he has done quite successfully ever since.

*Symptom Formation in Dreams.* A somewhat militant, determined young woman who had looked forward to a "modern, emancipated, equal partnership" found after she married that her husband, despite their pre-marital "intellectual agreements", expected a certain amount of feminine accommodation, if not subservience. The young lady developed anorexia and an intractable nausea and was referred for therapy. Within a week she brought this dream:

CASE 18(a). *Anorexia Nervosa*.

"My mouth felt stuffed with jelly and I felt sick at my stomach. You x-rayed my chest and found the trouble—a column of jelly was stuck in my gullet."

Her associations were direct and typically frank; her husband's penis was often too soft for entry—as "soft as a piece of feces." Once, to help his erection, he had asked for fellatio and she had indignantly refused—informing him that she "wasn't going to swallow that or any other kind of crap from him anymore." She had spent the night vomiting over the idea.

As may be anticipated, her scatologic depreciation of her husband was a meaningful introduction to her "disgust" (literally, out of the stomach) with all men and with many things about life that "stuck in her craw"—both expressions being favorites with her.

CASE 18(b). *Scatologic symbolism*. A dream with typical "anal symbolism" was described by an adolescent girl with chronic constipation which began when her father, eight years after the death of the patient's mother, remarried a "grass widow" with a 3-year-old son. The girl was ostensibly very fond of her stepbrother and kept him immaculately clean and dressed. One day, however, she brought in this dream:

"I was cleaning my baby brother, but instead of the bathtub I was using the toilet. Then a horrible thing happened—I flushed him down the drain."

Unfortunately, merely "making conscious" oral, anal or other equivalences has little value in itself: what must be accomplished is the much more difficult task of resolving the insecurities, rivalries, aggressions, regressions and other maladaptations of which the somatic symptom is only one facet.

*Aggression*. Hostility is often expressed in dreams with a peculiar specificity derived from (1) its true objectives and (2) the style of life of the patient.\*

CASE 19(a). A nightclub entertainer who prided herself on her convictions of racial equality but who hated and depreciated her many "lovers," including her employer, reported this dream.

"I was necking heavy with the nigger janitor right in front of my boss. Both were paralyzed and couldn't do a thing."

CASE 19(b). Similarly, a Salvation Army lassie, far from having inner contentment with the sublime mission of life, set for her by a dominant mother, reported:

"I dreamt a dream in Colorama. Christ came down off the Cross and danced as he was whipped. I as a child rose from my place in the audience and clapped

\* Quantification of Aggression in Dreams. L. Saul et al. (*Science* 119:382, 1954) have employed a 7-point "scale of unconscious aggression," against which they measured somatic dysfunctions. Dreams were graded as increasingly "aggressive" if they portrayed: (1) discomfort to objects; (2) discomfort to persons; (3) damage to objects; (4) damage to persons; (5) destruction of objects; (6) threatened death of persons.

my hands in time with the whipping to a cruel tune. But I thought the Lord will forgive us both, for She—I mean He—is good to children."

*Transference.* The patient's attitudes to the therapist are often revealed with symbolic frankness when their nature—e.g., infantile dependence, erotic attachment or destructive hatred—cannot be expressed more directly. Simple examples are the following:

CASE 20(a). *Dependence.* A shy school teacher, who kept repeating in his first interview that he needed "sympathetic" handling, revealed in a dream what he hoped the therapist would be like:

"A light was shining on a gentle, kindly, soft-spoken headmaster of T. [the boy's school the patient had attended]."

CASE 20(b). An earlier stage of childhood seduction is exemplified in the dream of a student who had attended the therapist's lectures, professed profound appreciation of them, and hinted broadly that he hoped that not only my "example and "inspiration" but also my "influence" would help him in his career:

"You turned into Anna Freud, and I had intercourse with you sitting on your lap."

*Erotic Subversion.* A shy, covertly mistrustful and withdrawn spinster, after long insistence on controlling all aspects of her therapy, signified her unconscious desire to have the therapist guide her through the guilt-ridden regions of sexual fantasy in this dream:

CASE 21. *Eroticism.*

"It was your car, but I had been driving it. We came to a red light and I wanted to turn left, away from my mother's house. I thought you knew the way better and asked you to take the wheel. While we were changing seats I felt a little randy." [To *red light* and *left turn* she associated prostitution and defined "randy" as a term used in her childhood on the farm to signify erotic arousal.]

CASE 22. *Sexual aggression.* A young wife, though intelligent and capable, had had early incestuous experiences and had thereafter used her physical attractions to intrigue and frustrate men. She revealed similar intentions vis-à-vis the therapist in this dream.

"Your wife was congratulating you on being made commissioner of something, but you looked like my older brother. I felt like making fun of you, bald head, wedding ring and all, but I thought that wouldn't work, so I thought I'd better be sexy, and I was. Just as you were getting real interested, though, your—I mean my—hour was up and I had to leave."

CASE 23. *Overt aggression.* Perhaps as vivid an intimation of this as any was the first dream of an outwardly polite but snobbishly patronizing matron who expressed her anger at the therapist for presuming to question analytically her assumed wisdom and rectitude:

“You were manipulating puppets from above, but I was higher in the stand than you. I vomited caustic and rubbed it into your eyes and mouth.”

CASE 24(a). *Resistance in dreams.* An engineer who had been rejecting both occupational and familial duties dreamt:

“I had to fix our TV at home to please my wife and kid, but I didn’t want to get a new tube and so I put in a resistor instead. I knew it wouldn’t work.”

CASE 24(b). From a colleague who also resisted maturity and who had recently been recommended for an unwanted promotion:

“Someone shoved a girl into my bed to play with, but I only touched her.”

CASE 24(c). From an arrogantly wealthy patient who had nearly wrecked his career and marriage by an overtly exhibitionistic affair with his wife’s sister.

“My fingernails were dirty and I was ashamed. I cleaned them, then my office secretary asked for a kiss. I screwed her and got my pants dirty. But I did business with people and they looked and it didn’t bother me.”

To *dirty fingernails* he associated his life habits of prim correctness in personal appearance, and added defiantly, “Secretaries are made to be screwed by those that can pay them—and I can.”

*Insights and Resolutions.* Dreams are also an index to the patient’s growing understanding, his inner resolutions of conflict and his reorientations in values and goals.

CASE 25. *Insight; dependence.* For example, the patient last cited, after nine months of therapy, realized that perhaps it was neither desirable nor profitable to continue to play the role of a spoiled child and to misuse mother and sister surrogates in the persons of his wife, sister-in-law, secretary and all other women. At this point he dreamt as follows:

“I was visiting at mother’s home and sleeping in her bed, but felt hemmed in, like I’d been clinging to her skirts too much. M. [his sister-in-law] came and lay beside me, but her breasts were shrivelled and the nipples turned in. I got up and put on a comfortable sweater. Father gave me a cigar and I went to work.”

CASE 26. *Insight; inhibitive.* A physician who had been excessively (and often deleteriously) overprotective of his patients, but who developed a professionally paralyzing phobia against touching anyone’s skin, expressed recognition of a crucial unconscious equation in the following dream:

“I was doing a physical examination and the patient suddenly seemed to be my baby boy. I wanted to commit sodomy, and got frightened. But then I re-

membered that my father was dead and he was a very fine man, but I'd never really liked the enemas he gave me. It was the patient again, and I went ahead with the examination."

Finally, an excellent example of an *insight dream* toward the end of therapy was contributed by an intelligent, talented, attractive woman with the following history:

CASE 27. *Insight; behavioral.* She was the eldest child of a prominent couple who were divorced when she was 8. Left to find her own securities, she tried the following in succession, with only marginal successes and recurrent frustrations: a career as a musical prodigy; then as a precocious music critic, then as a sexless, avant-garde, dilettante expatriate; then as her mother's traveling companion for a two-year trip around the world; then in a casual, fruitless marriage which she used mainly as a means of reestablishing her contacts and "social position," and finally as an unhappy divorcée still trading unnecessarily on her family name and connections rather than on her own talents and potentialities. After her past and present patterns of behavior had been explored during eight months of therapy, the patient altered many of her previous values and attitudes, secured a creative job commensurate with her capabilities, and entered into what promised to be a favorable marriage. During this period she dreamt the following, which she herself called "a critique of my life":

"I felt alone in an empty house with only dolls around. Then I was older and giving a musical recital, just following the leader but not really knowing or liking the music I was playing. A girl with long hair and esoteric looks—maybe myself—asked me in fancy words to explain what I was doing, but I got angry and wouldn't. Then I was dancing as a man would—there were no women around. Next, three girls my age appeared: one was masculine, one was dressed like a child and one was divorced and gamboling about as though she were fourteen. I felt scorn for them, but maybe they were all me too. Then I was hostess at a huge party—a big production, but nobody helped or paid much attention to me. I screamed at mother about it, and she said, 'come with me,' but didn't take me anywhere. There were lots of beds in the house where I could put people up, but then I wanted to be alone and finally told them to get their own food and make their own beds. Then there was a big parade outside the window, and Col.——[a notorious publicist] waved for me to come down and join him in it, but I felt tired. I went to mother again and asked her to let me be much younger and she sent me to Dr.——[a psychoanalyst who first treated her] but somehow I knew then it wouldn't work. So I took off my party dress and woke just in time to go to work."

The communications reproduced here under the category of dreams were, of course, selected for their relative clarity and directness, but even with the best of techniques to keep the patient from misusing an infinite repertory of dream symbols and actions, such communications will not al-

ways be as frank or forthright. However, though the therapist, with increasing experience, may acquire skill in penetrating obscurities, he should not misapply this skill in confronting the patient with prematurely conveyed discernments and interpretations which may actually be disruptive and harmful. It must never be forgotten that psychotherapy, like surgery, is not merely a matter of diagnosis and exposure, but also of respect for tissues and exquisite skill in timing and functional repair.

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## Chapter 5

### MENTAL RETARDATION

“Mental deficiency” was described in the Therapeutic Papyrus of Thebes in 1552 B.C. In 1620, Bonnet of Madrid published his studies on the training of a mentally defective deaf-mute, and by the 18th century the problem was so widely recognized that Boerhaave at Leyden, Morgagni at Padua, and Haller at Gottingen had made instruction on mental deficiency part of the medical curriculum. In 1801 and 1806 the young French physician, Itard, published his studies of “Victor, the wild boy of Aveyron,” who had been captured when aged about twelve, roaming the woods in animal-like ignorance and savagery. Itard’s prophetic use of various training techniques, such as progressive association, recognition and manipulative learning, inspired his pupil Seguin to found an elaborate system of “medical education,” widely adopted despite Binet’s critique of it as “. . . a vague pedagogy adorned with the pompous title of the medico-pedagogical method.”

In current usage, mental retardation denotes either congenital inadequacy or subsequent organic impairment of *capacities* to perceive, remember, assemble and deal adequately with the environment. Such defects are generally distinguished on the one hand from *abulia*, which signifies a lack or weakness of motivation, energy or initiative, and on the other hand from maladaptive *functional* neurotic or the psychotic disorders (v.i.) which may occur in persons with all configurations of intellectual capacities. Further distinctions may be made between *amentia* resulting from hereditary causes or injuries to the brain at birth (to be dealt with more extensively later in this series), and *dementia*, which signifies a deterioration of intelligence due to cerebral disease in later life.

More explicit definitions require an understanding of what is meant by “intelligence.” Unfortunately, since the isolation and measurement of intellectual capacities constitute one of the most controversial fields in clinical psychology, only a few of the leading concepts can be outlined here. One of the most comprehensive and pragmatic approaches is that of E. C. Tolman, who regards intelligence as the interrelated capacities of an organism (a) to perceive its environment through various sensory modalities (*discriminanda*), such as sight, sound, touch, taste, smell,

movement, temperature, etc.; (b) to *integrate* these sensations into total configurations (*gestalt apperceptions*); (c) to attribute meaning (*symbolization*) and personal reference (*value*) to them in terms of retained past experiences (*memory*); and (d) to *respond* to such differentiated apperceptions by internal and external reactions of various degrees of finesse, versatility and efficiency (*manipulanda capacities*).

Excluding instances in which the organs of sensation and motor expression are crippled by malformation, injury or disease, and presupposing that the behavior of the organism is adequately motivated and is not disrupted by conflicting internal drives, its intelligence can then be graded as high, normal or low in relation to the performance of other organisms confronted with similar environmental problems. Intelligence is thus broadly equated with *behavioral capacity*, but, largely because of the traditional (though often spurious) distinctions inherent in our habits of thought and speech, attempts are usually made to define human intelligence in more "specific" terms, such as memory, logic, mathematical ability, capacity to abstract, categorize, originate, etc.

### "FACULTIES"

In the time of Franz Joseph Gall (1758-1828) and J. G. Spurzheim (1776-1832) on the continent, George Combe (1788-1858) in Scotland, and Amariah Brigham (1798-1849) and others in America, these functions were actually regarded as separate "mental faculties," each residing in separate portions of the brain. Indeed, Gall and Spurzheim in their system of *phrenology* distinguished no less than thirty-seven faculties (e.g., destructiveness, amativeness, cautiousness, language, music), the relative strength or weakness of which could be measured by the size and shape of various portions of the skull. Such notions appeared again in the writings of Lombroso (1836-1909), who thought that *stigmata of degeneration* (e.g., towering cranium, low forehead or hair line, pointed ears) indicated an atavistic reversion to *primordial types* and could thereby be correlated with intellectual and "moral" deficiency in modern man. Later studies by C. D. Spearman, Thurstone and others in the psychology of individual differences, and by A. Hrdlicka and D. G. Paterson in comparative anthropometry, have refuted these early findings; nevertheless, from such investigations have also come reliable indications that certain talents and capacities do vary from person to person and that they may be correlated with hereditary and constitutional (though not racial or adult morphologic) factors. Thus, by an elaborate statistical analysis of many thousands of special tests, Thurstone isolated certain partly independent capacities or *vec-*

tors which approximate what may be called *memory*, *verbal comprehension*, *verbal fluency*, *space visualization*, *facility with numbers* and—less specifically—*speed of response* and proficiency in *induction*, *deduction*, *perception*, *integration*, *abstract judgment* and *flexibility of concept formation*. Additionally, Thorndike distinguishes *mechanical*, *social* and *abstract* intelligence—the latter, according to Kurt Goldstein, being a more elaborate intellectual capacity than *concrete* or *stimulus-bound* thinking and correspondingly more vulnerable to the effects of injury to the cerebral cortex. Carl Spearman and the British school of psychometrists propose a two-factor theory which holds that although there may be specific determinants (*s-factors*) for characteristics such as *perseveration* (repetitiousness), *fluency*, *will* and *speed in thinking*, all special abilities are interrelated by the general factor *g*, representing comprehensive intelligence. Accordingly, an individual particularly talented in one respect is likely to be highly endowed in other capacities also. On the other hand, marked exceptions to this rule certainly occur in the form of *idiot-savants*; i.e., persons who have some remarkable endowment such as an infallible memory, a spectacular proficiency at playing chess or the ability to make accurate mental calculations with lightning speed—and yet are intellectually subnormal in most other respects.

#### THE MEASUREMENT OF INTELLIGENCE

In 1904, Alfred Binet (1857-1911), professor of psychology at the Sorbonne, was asked by the Minister of Public Instruction to devise a method by which children who were doing poorly at school "because of lack of ability [could be distinguished from those] who were retarded because of laziness or lack of interest." In collaboration with Simon and others, Binet assembled a series of tests designed to determine the so-called "mental age" (M.A.) of any child (i.e., his native intelligence) irrespective of his experience or training. The M.A., when divided by the chronological age (C.A.) of the child, yielded an "intelligence quotient" (I.Q.). For example, a child of 12 with a mental age considered normal for one 8 years and 9 months (8 3/4 years) old could be graded as I.Q. = 73, with I.Q. 100 (range 90 to 110) being considered as average or "normal." Various degrees of "mental deficiency" were then made to correspond roughly to levels of social adaptability as defined, for example, by the English Deficiency Act of 1927, as follows:

"*Idiots*" (I.Q. less than 20) are "persons in whose case there exists mental defectiveness of such a degree that they are unable to guard themselves against common physical dangers."

"*Imbeciles*" (I.Q. 20 to 49) are ". . . incapable of managing themselves or their affairs, or in the case of children, of being taught to do so."

The "feeble-minded" (I.Q. 50-79) are "persons in whose case there exists mental defectiveness which, though not amounting to imbecility, is yet so pronounced that they require care, supervision and control for their own protection or others," or, in the case of children, that they appear to be permanently incapable by reason of such defectiveness, of receiving proper benefit from the instruction in ordinary schools." In the United States, the three deciles of I.Q. in this group were formerly referred to, respectively, as *low-grade morons* (50-59) (a term introduced by Goddard), *high-grade morons* (60-69) and "*borderline mental defectives*" (70-79).

With regard to clinical and causative factors, the congenital defects or *amentias* are subclassified into *genetic or maternal metabolic*, causing specific abnormalities in embryonic development, whereas the *dementias* are divided into post-traumatic (due to brain injury), *postinfectious* (meningitic and encephalitic), *with cranial abnormalities* (as hydrocephaly or microcephaly), or *with epilepsy or other organic disease*. However, in later nomenclature, the terms *severe*, *moderate* and *mild* mental retardation are substituted for *idiot*, *imbecile* and *moron*, and, aside from the designations *familial*, *hereditary* or *undetermined*, and other special terms are eliminated in favor of more specific notations as to the etiology, nature and alterability of the deficiencies described.\*

The introduction of the Simon-Binet scales into the United States by Goddard, Huey and Kuhlman stimulated great interest in the field in this country, and led to the establishment of research and corrective institutions, such as the Training School of Vineland, New Jersey, Letchworth Village in New York and the Wayne County Training School in Michigan. Unfortunately, as often occurs in such situations, diagnostic enthusiasm exceeded the bounds of scientific validity. For instance, H. H. Goddard, in *Feeble-mindedness; its Cause and Consequences* (New York, 1914), wrote that "the criminal, the pauper and the intemperate" were predominantly "mentally defective" and that others thought that "feeble-mindedness" was also the root of vagabondage, prostitution and myriads of other social ills. Indeed, so insistent did the proponents of this monothetic approach become that pressure was put on nearly every state legislature to make sterilization of the "mental defective" a mandatory procedure. It is now known, however, that the intelligence of criminals follows the normal distribution of the general population, that social delinquency in its various forms is much more dependent on economic, cultural and other environmental in-

\* For more recently developed clinical tests for various forms of mental retardation, see Volume I, Chapter 5 of this *Serial Handbook*.

fluences (F. Alexander and Healy), and that in any case, as David Levy states, "Programs advocated by the eugenists with a view to raising the mental level of the entire population by sterilizing or isolating those who fall below artificially selected intellectual standards have been found to be neither practical nor scientific."

### CLINICAL RELEVANCE

Evidently, then, except at the lowest levels, intelligence cannot be closely correlated with general level of failure or success in life, since personal factors such as motivation, body health, emotional control and social adaptability and a favorable environment are highly important. These are also, as we have seen, in continuous interplay with extrinsic circumstances such as the demanding or tolerant nature of the culture in which the individual lives, his basic or special training, and the availability of a niche in the social order especially suited to his abilities. In general, however, a person capable of progressing satisfactorily through a primary or high school education, learning enough about his cultural milieu to conform adequately to occupational and other social demands and capable of maintaining adequate familial or other group relationships may be judged to be of "normal" intelligence. Failure in these respects at any time may be due to ill health, to overwhelmingly adverse environmental circumstances or to the elicitation of conflicts in sensitized subjects leading to the development of neurotic or psychotic reactions. Such reactions are modified only in that intellectually handicapped persons show relatively simple aberrations of conduct, whereas in highly intelligent patients, the neurotic and psychotic symptoms may become correspondingly elaborate and complex.

### PREVENTION AND TREATMENT OF MENTAL RETARDATION

As to the eugenic approach, H. S. Jennings (*Encyclopedia of the Social Sciences*) writes that in view of the recessive nature of these forms of mental deficiency that have a possible hereditary basis, "the prevention of the propagation of all 'feeble-minded' in the United States would reduce the number in the next generation by only about 11 per cent . . . In later generations, preventing the propagation of the 'feeble-minded' would have little further effect save to keep the number down to that already reached." Since many of the severely retarded are sterile or sexually unacceptable, they propagate relatively rarely. Eugenic efforts, therefore, have

concentrated on the mildly retarded, with wide differences in procedure among the various states. Present knowledge indicates that measures designed to reduce the incidence of mental retardation could much more effectively be directed toward adequate prenatal maternal care, to the prevention of neonatal asphyxia or trauma (particularly cerebral), and the control of childhood diseases and injuries.

Treatment of reversible dementias consists, of course, in the elimination insofar as possible of the physical factors (hypothyroidism, vitamin deficiency, anemia, infections or tumors of the central nervous system) which impair cerebral functioning. However, if an ineradicable amentia is present, or if acquired defects remain, treatment consists of (a) providing the proper environment, whether institutional in severe cases, or in private homes for those less handicapped, (b) protecting the defective from failure or exploitation, and (c) utilizing his special talents to best advantage for himself and society.

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## Chapter 6

### PSYCHOPHYSIOLOGIC DYSFUNCTIONS

Within the past several decades concerted efforts have been made to "correlate" psychiatry and psychoanalysis on the one hand with medicine and surgery, on the other in a proposed "new" field designated "psychosomatic medicine." These efforts have had salutary results in recultivating scientific and clinical liaison between psychiatrists and their colleagues in other branches of medicine; however, excessive enthusiasm has sometimes obscured the significance and limits of this otherwise desirable reunion. It may therefore be profitable here to review certain fundamental considerations.

Inevitably, every illness is "psychosomatic": a frustration, a fright, an infection, an injury, or any other symbolic or "actual" trauma involves the patient's "feeling," "thinking" and "willing" as expressed simultaneously in his external (social) and internal (physiologic) responses. In this integrated reaction, "mind" and "body" can be only artificially—and not meaningfully—distinguished; in this sense, all medicine, including psychiatry, is "psychosomatic," and the term thereby becomes, as many have felt, annoyingly redundant. Yet some of its advocates persist in dualistic searches for the "mental factors" in organic disease; others look for the organic substrate or etiology of "mental disease," and still others use the term with connotations that vary from psychoanalytic "formulae" for various "organ neuroses" to the neurochemistry of schizophrenia (Chapter 7). However, since the term *psychosomatic* has become deeply rooted in the vocabulary of medicine, it will be employed in this book with perhaps its most useful meaning: to designate those total behavior disorders in which specific somatic dysfunctions play a prominent role.

### PERSPECTIVES

Ancient Greek medicine readily acknowledged the fact that "travail of the soul" could seriously disturb the functions of the body; for instance, in the Aesclepiad Sanatoria, physical diseases were treated by music and religious and philosophical discussions, as well as by diets, baths, exercise and drugs. Nor did the deviated expressions of erotic conflicts remain unrecognized: Soranus records that Hippocrates himself prescribed "lighting the torch of

Hymen" for women with hysterical disorders. However, a belief in the dichotomy between ethereal "soul" and substantial "body" characterized medieval thought, and later Cartesian dualism was widely accepted as a basis for medical practice. By the nineteenth century, however, medicine was making such rapid advances under Pasteur (1822-1902) and Koch (1843-1910) in bacteriology, and under Virchow (1821-1902) and others in pathology, that it was thought to be only a matter of time until all illnesses would be traced to the purely "somatic" factors of infection, injury and resultant tissue change. In effect, it was not until Charcot (1825-1893), Bernheim (1840-1919), Freud (1836-1939) and others had demonstrated the role of motivational factors in "hysterical" dysfunctions that the purely materialistic concept of behavior began to be modified. William Beaumont, a U.S. Army surgeon, devoted years to the study of Alexis Martin, a patient with an abdominal fistula, in whom the gastric facets of affective reactions could be directly observed. (*Experiments and Observations on the Gastric Juice and the Physiology of Digestion*, Plattsburgh, F. P. Allen, 1833).

Fortunately, progress in the reintegration of psychiatry and medicine has been fairly rapid in the last three decades. In this country the psychophysiological approach to such disorders has been further developed by Flanders Dunbar, Arthur Mirsky, Franz Alexander, Eric Wittkower, Harold Wolff, Wilfred Dorfman and others since the founding of The Psychoanalytic Institute at Chicago in 1932. In 1938 Flanders Dunbar published her compendium on *Emotions and Bodily Changes* and the next year assumed the editorship of a new journal, *Psychosomatic Medicine*, devoted to the field. In 1942 the American Society for Research in Psychosomatic Problems was founded in New York, and since then the Society of Biological Psychiatry and the Academy of Psychosomatic Medicine have served as scientific meeting grounds for anatomists, physiologists, neurologists, psychologists, analysts, psychiatrists, and all others desirous of pooling their specialized knowledge and techniques in the study of the correlations of external and internal (i.e., psychosomatic) behavior.

#### CLINICAL FORMS OF PSYCHOPHYSIOLOGIC DISORDERS (DSM II, 305)

There have been many dialectics as to whether physiologic changes are "subjectively" reflected as "emotions" (James, Lange, Kantor, et al.), or whether, as Ferenczi and others implied, "mental" processes primarily influence somatic functions. The question itself, of course, revolves about what is meant by "subjective" (are not all concepts?), "emotion" (*e-moto*,

to move out), "mind" (pay attention and obey), or "somatic" (what is not?)—terms which have been discussed in various contexts elsewhere in this volume. Operationally, the distinctions between "psyche" and "soma" are artificial; instead, every pattern of behavior is a total response, the "psychic" and "somatic" aspects of which may be considered as follows:

*Physiologic accompaniments of intensive adaptational ("acute emotional") reactions.* As noted in Chapter 2, *anxiety* is one of the most frequent and easily recognized of psychosomatic syndromes and is either an overt ("conscious") or covert ("unconscious") component of nearly all neurotic reactions. As we have seen, anxiety is felt subjectively as a diffuse and unformulated apprehensiveness and reflected somatically in palpitations of the heart, irregular catchy respirations, feelings of a lump (*globus*) in the throat, flushing of the skin, cold sweating, fluttering sensations in the abdomen, tremulousness and, in severe degrees, incontinence of urine or feces. The expressions of *fear* are only slightly different, in that the subjective perceptivity is fixed on some external object or impending event and the physiologic accompaniments generally include hypersensitivity to stimuli, blanching instead of flushing of the skin, pupillary dilations, erection of the hair and muscular tensions. *Rage* may also be characterized by any one of the expressions already mentioned, including subtler physiologic preparations for efficient action in "fight or flight." As Cannon and Britton have shown, rage is also manifested in a cessation of gastrointestinal movements, a rise in blood pressure, increased content of epinephrine in the blood serum (hyperglycemia in human rage has been questioned by Mirsky), and a release of platelets and ions that would expedite clotting of the blood if the organism was injured. However, overwhelming anxiety or rage may induce what Kurt Goldstein has called a *catastrophic reaction*, with fall in blood pressure, rapid thready pulse, visceral inactivity and other symptoms of severe physiologic exhaustion. In contrast, tension-relieving affects, such as equanimity or amusement, are characterized by a fall in blood pressure and muscular relaxation, or the lachrymation and staccato exspirations of laughter.

*Subacute affective disturbances.* Here the somatic dysfunctions are less dramatic but may account in considerable measure for the relatively mild but persistent and annoying discomforts and physical inefficiencies suffered by persons under continuous adaptational stress. "Tension headaches" during or immediately following harrowing experiences furnish one example of such reactions, and may increase to nausea or vomiting, fleeting visual disturbances and weakness or prostration for several days. Less apparent but more subtly debilitating is a form of irritable exhaustion which may affect persons who try to overcome feelings of inadequacy by continuous intensive effort. Eventually, such patients begin to experience

apathy, lack of zest and initiative, and rapid fatigability to the point of collapse.

*Theoretic ontology of visceral and sensorimotor disturbances.* In its earliest months, the human infant is dependent for its very existence on maternal care and feeding; hence, even before it attains clear consciousness, it has necessarily equated primitive oral and gastric satisfactions with experiences of being protected and loved. Conversely, later deprivations, as in neglect or sudden weaning, become associated with fears of rejection and insecurity. The infant, when helpless and alone, can summon fondling, warmth or other needs only by crying, with the result that dermal sensations and vocalizations also become charged with highly significant appeals for comfort and "fellow-feeling." A little later in life the child becomes forcibly acquainted with the necessities for social conformities during the period of bowel training, and thus unconsciously associates colonic and anal functions with resentments of discipline and authority and therefore with reactive hostilities and aggressions. Finally, the growing child's earliest erotic experiences are centered less in its genital organs that in muscular activities directed toward seeing, hearing, touching and exploring—circumstances that render more credible Freud's contention (unfortunately obscured by the term "hysterical conversion") that sexual conflicts in later life may be expressed symptomatically in disturbances of sensorimotor as well as genital functions. In fact, psychoanalytic theory holds that all of these associations between stages of "libidinal development" and specific organ-systems persist unconsciously but immutably in the psychosomatic organization of the adult. Accordingly, when motivational and adaptational stresses become sufficiently intense or prolonged, specific *psychosomatic disorders* may make their clinical appearance as follows:

#### **Organ Dysfunctions**

These represent various disturbances in the regulation of the organs of the body.

*Gastrointestinal system* (305.5). Excessive acidity in the secretions of the stomach, combined with increased tonicity and rapid emptying time, may cause symptoms of "heartburn" and abdominal discomforts, and may lead to the formation of a gastric or duodenal ulcer. Such dysfunctions are likely to occur in passive, dependent persons who long for love and security but who submerge such longings under a facade of blustering self-sufficiency. The corresponding gastric hyperacidity and hypertonicity, spasms and ischemia expressive of a longing for nurturance, combined with concurrent pyloric hemorrhages and erosions and thus lead to the formation of a peptic ulcer.

Stewart Wolf, as did Beaumont, has confirmed this sequence by direct observation of the stomachs of patients placed under emotional stress.

*Anorexia nervosa* is a more chronic and debilitating disorder, characterized by retarded physical and sexual development, self-starvation and restless hyperactivity, sometimes resulting in extreme emaciation. While endocrine insufficiencies may play an important part in the causation of this syndrome, it generally occurs in women who have remained infantile, unemancipated and demanding in their emotional orientations, feel unwanted, and attempt to retain a deeply ambivalent dependency in their interpersonal relationships. (Cf. Masserman: *Principles of Dynamic Psychiatry*, Case 40).

*Colonic distress* (flatulence, urgency, spasms, diarrhea and other symptoms) is a fairly frequent accompaniment or residue of intense anger, associated theoretically with the period of bowel training, and it may become chronic in persons whose resentments of discipline remain unresolved.

*Cardio-pulmonary dysfunctions* may take various forms, e.g.:

*Cardiac neuroses* (305.3) are characterized by recurrent symptoms resembling those of coronary thrombosis and heart failure, i.e., pains in the left chest and arm, rapid pulse, sweating, dyspnea and faintness. This syndrome usually occurs in relation to episodes of intense anxiety.

*Vascular hypertension* is a common functional disturbance in the restless and often successful type of individual whose initiative and drive are expressions of excessive, though repressed, hostilities and aggressions. Unfortunately, severe and frequent bouts of functional hypertension may lead to organic damage in the arteries (sclerosis), kidneys (nephrosis) and heart (coronary occlusions), so that the disturbance may become progressive because of irreversible tissue changes.

*Asthma*. An asthmatic attack may often be precipitated by a sudden deprivation, with the bronchial constriction symbolizing a repressed expiratory cry for the lost mother.

*Other organ neuroses*, such as eczematous rashes (neurodermatitis, 305.0) and some forms of chronic arthritis, have also been thought to be of "functional" etiology, whereas pseudocyeses are demonstrably so. The following case is illustrative:

*CASE 28. Psychophysiological pseudocyesis with amenorrhea and vomiting* (300.8). A 21-year-old girl was referred by an obstetrician with a note that, whereas he had been unable to detect any signs of pregnancy, the patient not only insisted that she was pregnant, but also attributed her anorexia, vomiting, amenorrhea, abdominal pains and general irritability to this condition. Physical examination showed only a gaunt, markedly undernourished girl who affected a posture and mode of abdominal relaxation that gave her the appearance of early pregnancy. There were,

however, no other physical signs of this, and, as previously, the Aschheim-Zondek test was negative.

The history and mental status examinations revealed a wealth of neurotic patterns, which need not be detailed here. One of particular psychosomatic interest had developed as follows:

The patient's father, an irresponsible, alcoholic psychopath, had seduced the girl into sex play at an early age, and had begun to attempt intercourse with her when she was about 12. This had failed primarily because the patient's genitalia remained infantile, but the two continued the practice of mutual masturbation. At 18, the patient, jealous of a younger sister whom the father had begun to prefer, eloped to another city with a young man who, after a single frustrating attempt at sexual relations with her, "did the right thing" and married her. The patient, however, was unhappy in her own home; intercourse with her husband again proved impossible and after a few months he lost patience and brought her back to her parents. There she discovered that her sister was illegitimately pregnant and immediately suspected her father—a suspicion soon confirmed by the sister. The patient missed her next menstrual period, began to believe herself pregnant by her own husband, and thereafter rapidly developed the pseudocyclic abdominal enlargement, vomiting, dietary idiosyncrasies and emotional instability that brought her to the Clinics.

*Course of Therapy.* Under Amytal narcosis administered as part of the initial sedation for her insomnia and her restlessness, the patient furnished additional material which indicated that her unconscious desires to be pregnant were compounded of the following: a jealous identification with the sister, with aggressively tinged wishes to reveal her own incestuous relationship with the father; a longing to force her way back into the family circle as a prospective mother forsaken and requiring prenatal care; a similar wish to regain her husband in a protective, nonsexual relationship—or finally, failing all these, a regressive preemptive flight to the haven of a maternity hospital.

The patient showed initial improvement under routine care and was fairly easily induced to relinquish her fantasies of being pregnant. However, she became increasingly demanding of special foods, individual hours of visiting and other indulgences, developed uncompromising animosities to student nurses and other sister surrogates on quite fanciful pretexts, and finally became exceedingly uncooperative. During the latter episodes, distortion of affect and ideation became apparent; for instance, the patient, with a peculiarly remote equanimity, stated that an elderly ward janitor had been hypnotizing her. Commitment was therefore recommended, but the family refused and took her home. There she ate very little, began vomiting frequently and finally became so cachectic that the possibility of Simmonds' disease was seriously considered. She has since been confined to various sanatoria.

### Sensorimotor Neuroses

As late as the turn of the century it was thought by many that hysterical dysfunctions were confined to women, in whom they were caused by the wandering of the uterus (Latin: *hysterus*); Kustner's *Lehrbuch der*

*Gynakologie*, published in 1906, still contained the assertion that "diseases of the uterus and its adnexae . . . lead to the most pronounced and frequent symptoms of hysteria." Freud classified hysterical disturbances among the *conversion neuroses*, since he thought that they expressed a deviated and "converted" form of sexual energy (libido) in both sexes. Some sensorimotor aberrations may indeed have erotic connotation, as in the following examples:

CASE 29(a). *Psychophysiologic reactions of special sense; amaurosis* (305.8). An adolescent girl with intense sexual curiosity contrived, while unobserved, to witness intercourse between her parents. However, when she was discovered she developed intense guilts and fears and began to suffer attacks of functional blindness (hysterical amaurosis), as though in denial of, and expiation for, her forbidden act.

CASE 29(b). *Psychophysiologic paresthesia by identification*. A 54-year-old spinster complained that the right side of her face and neck was affected by severe pains, the cause of which could not be determined by physical and laboratory examination, and which persisted despite all medication. The psychiatric history revealed that the patient, a shy isolated person, had but one friend—a neighbor whose husband some six months previously had developed a malignant right cervical tumor. On the patient's recommendation he had been taken to the University Hospital, where he died in a few weeks. The patient's friend, in her depth of grief, had turned furiously on the patient with the accusations that the latter had "sent him to die" and that, had she not done so, he would still be alive. Soon after this scene the patient herself developed facial pains very like those of the deceased husband and promptly entered the University Hospital with the emphatic statement that she herself was certain it was "the best hospital in the country." Other data, as expected, revealed another and less conscious dynamism than this relatively simple one of self-justification: the attachment of the two women friends had bordered on homosexuality, and the patient was symbolically identifying with the dead husband.

Therapy consisted in simple reassurances to the patient that "nervous pains" in any part of the body could be caused by "worry and aggravation" and concurrent reexplanations to the widow that her husband's illness had been inevitably fatal despite the best of treatment. Once a reconciliation between the women had been effected, the patient's pains responded promptly to placebos and mild massage and she was discharged symptom-free.

CASE 29(c). *Psychophysiologic musculoskeletal reaction*. A 22-year-old married woman, of normal intelligence but limited educational background, was referred by an obstetrician because, for a year after the delivery of a stillborn baby, complicated by a mild puerperal thrombophlebitis of her right leg, she had continued to have an inexplicable spastic paralysis of this extremity.

The psychiatric history was relatively simple. At the age of 18 she had married her illiterate, stolid but conscientious and devoted husband mainly because she desired to escape from the drudgery of factory work, but instead of enjoying her

ticipated freedom, she had been obliged to assume the unexpected responsibilities of a wife and prospective mother. Her first child, delivered with difficulty a year later, was born deformed, and its care added greatly to her burdens and disillusionments. Within a few months, much against her unspoken desires, she was pregnant again, and this time she had an even more stormy pregnancy, terminated by stillbirth and a residual thrombophlebitis. In treatment for the latter complications, the obstetrician prescribed rest, warm packs, light massage, and—psychologically most important to the patient—a suspension of intercourse until she was “completely recovered.” The husband, of course, was informed of this and remained continent for months, although finally his growing impatience forced the patient again to seek treatment for what she called, with significant lack of anxiety, her “chronic milk leg.” In the psychiatric interview the patient quite innocently stated that “there were certain things about her leg she “couldn’t understand,” as one example, why it was “better” throughout the day, yet so “painfully stiff” in adduction at night that intercourse with her husband was impossible. Fortunately, the symptom cleared rapidly when the patient recognized its relationship to her fears of a third pregnancy, although her self-respect and rapport were preserved by making this point implicit, but never traumatizingly explicit. Furthermore, since insight without action never solves a dilemma, the therapy was directly implemented by inducing her husband, through appeals to his own self-interest, to help in the contraceptive techniques that they both now desired.

*Comment:* A psychodynamically significant lack of concern about a symptomatic disability that serves to resolve a neurotic conflict was called “*la belle indifference*” by Janet. Clinically, however, anxiety can be readily elicited if the symptom is prematurely threatened by the therapist.

Of course, experience in industrial and military psychiatry has shown that functional sensorimotor disabilities may be related to other than purely sexual conflicts:

A workman with a trifling accidental injury may feel that he has been inadequately protected or unjustly treated by his employer, and may therefore develop an intractable functional paralysis of the injured member as long as his attitudes of covert hostility persist. To evade possible retrIBUTions and punishments for such hostilities, the “functional paralysis” would also express innocuous passivity, and this reaction would be further strengthened if the “illness” produced *secondary gains* such as hospital care and financial compensation that satisfied the patient’s regressive wishes. Such individuals may become unconsciously “accident prone” (H. Dunbar) and may continue to constitute industrial hazards to themselves as well as their employers.

Similarly, acute “combat neuroses” are often expressed in functional blindness, deafness, mutism, paralysis of the shooting arm and other impairments of perception and motor control that make it impossible for military authorities to return the patient to combat. Such dysfunctions may not be governed by “de-liberate intent” and are thus distinguished from *malingering*. Nevertheless, they are of evident symbolic and adaptive (psychosomatic) import.

### Somatic Dysfunctions in Psychotic States

Finally, severe and chronic behavior disorders are often accompanied by the following physiologic disturbances:

*Mania* (296.1). In line with emotional lability and press of activity, there is hypersensitivity to sensory stimulation, rapidity and irregularity of cardiac action, variable appetite, urinary urgency, frequent small bowel movements and general motor restlessness.

*Depressive states* (296.2), in contrast, are characterized by insomnia, anorexia, loss of weight, constipation, amenorrhea, diminished sexual desire, and a pervasive lethargy sometimes more pronounced during the morning and late evening hours.

*Schizophrenic psychoses* (305.9) have a wide range of somatic expressions, including lability of body temperature (poikilothermy) variable disturbances in the metabolism of sugars and fats, possible alterations in hormonal balance, muscular tonus (flexibility or catatonia) and electrocortical rhythms, especially in the central reticular formation and in the septum pelucidum (R. Heath).

With this preview, we may turn first to those behavior syndromes generally accompanied by neuromuscular and organic dysfunctions.

### Other Types of Psychophysiologic (Formerly "Hysterical") Disorders (305.9)

The term "hysteria" has been used with many different psychiatric connotations. Formerly, as noted, it was applied to a state of marked emotional and motor excitement with or without syncope and subsequent amnesia, that affected professedly delicately bred and sensitive women placed in (to them) acutely stressful situations—a definition that persists in the lay term "hysterics." The concept is still employed with somewhat similar implications in several compound terms as follows:

*Hystero-epilepsy* (305.1). This designation is applied to "epileptoid" motor seizures that differ from true epilepsy in being emotionally conditioned, covertly expressive of repressed inner urges, unaccompanied by neurologic or electroencephalographic signs of organic disease, and generally without the residues of headache, muscular tension, fatigue or impenetrable amnesia.

CASE 30. *Psychophysiologic musculoskeletal reaction: hystero-epilepsy* (305.1). A youth of 16 with a covertly erotic attachment to an older sister, expressed his incestuous fantasies through "epileptoid convulsions," in which the muscular movements were almost unmistakably either masturbatory or heterosexually erotic in character.

*Hysterical (pseudo) psychoses* (306.9). These unfortunate terms are intended to describe (a) acutely disturbed states in which the patient *simulates* acute mania or excited schizophrenic behavior or (b) chronic aberrations of thinking and conduct in which the patient may act out his concepts of psychotic behavior without, however, psychotic disturbances of thinking or true hallucinatory or delusional imagery being present. Hysterical psychoses may occur in imprisoned criminals seeking mitigation of guilt with or without an admixture of malingering; in either case, the reaction is somewhat broadly termed the *Ganser syndrome*. More meaningfully, the diagnosis of hysterical psychosis is applied to a reaction occasionally seen in severely neurotic and avidly suggestible patients who more or less consciously identify with some psychotic person or group, or in others who for various reasons wish to act out their own concepts of psychotic behavior as derived from hearsay or reading.

*Hysterical fugue states* (307.4). These are periods lasting from a few minutes to several months or years, during which the patient professes to have no, or almost no, memories of his previous existence, and during which he may act in quite unaccustomed ways. In the more spectacular fugue states he may "wake" miles from home, totally unaware of his identity or whereabouts, and begin life "anew," i.e., with a new occupation and new marital and social relationships. However, even a superficial examination will readily disclose that the patient has retained advantageous skills of language, education, social manipulation, etc., and that, in fact, his amnesia for his past, far from complete in any case, can be further dissipated by measures calculated to make recall of his past wholly, instead of merely professedly, acceptable to the patient. It will then generally be found that the fugue state had been precipitated by either an extremely acute adaptational problem, or one that had mounted slowly to an intensity that had forced the patient to repress his anxiety together with all perceptions and memory relevant to it. After a period of wandering, he would then "come to full consciousness" only after sensing that he had escaped completely from what, to him, had been an intolerable environment. Sometimes there are subsequent attempts to escape by similar means, occasionally back to some "former identity" with amnesias for "identities" between. Alternations between such "discontinuous states of consciousness" were of particular interest to Morton Prince, who regarded them as manifestations of "double" or "multiple" personality, but this somewhat theoric interpretation obscures the dynamic and adaptational import of such dissociative defenses.

### Psychosomatic Specificity

A recurrent issue as to the etiology of various psychophysiologic disorders is whether they are expressions of unconscious conflicts of specific motivations and interpersonal adaptations. Franz Alexander, Thomas French, Leon Saul, George Pollock and others have contended that such correlations exist, here briefly reviewed:

*Gastric hyperacidity and hypermotility*, sometimes resulting in *peptic ulcer*, are somatic expressings of repressed cravings for lost maternal sustenance manifested as a continuous gastric preparation for food.

*Recurrent hypertension* is a sign of unconscious rage and hostility generally directed against father-symbols in reenacted Oedipal situations.

*Neurotic asthma* is a fixation of bronchial spasms symbolic of the cry of the deserted infant.

*Neurodermatitic eczema* is displaced lachrymation and is part of a syndrome of frustrated yearning for touch and fondling.

This list has been extended to include other specific formulas purported to correspond to organic dysfunctions as delimited as glossitis, glaucoma and even warts,\* even though (a) nearly all such formulas are derived from uncontrolled, preemptively selected and largely anecdotal excerpts from the therapy of a relatively small number of patients, and (b) most of the formulas themselves are so vaguely phrased as to be interchangeable. In practice, the fantasies of almost any patient, if sufficiently explored will include not only all the psychosomatic associations cited, but also most all others conceivable—including those that would be considered “psychotic” outside the free-associative process.

Conversely, patients actuated by relatively constant psychodynamisms can show an exceedingly variable symptomatology.† One example may suffice:

\* Relatively simple explanations for supposedly abstruse “psychosomatic correlations” are recorded in the literature. For example, H. Rattner (*Arch. Derm. & Syph.* 60:624, 1949) reported a female patient who suffered three days each month from what a psychiatric consultant had called “vicarious palatitis.” Investigation showed it to be wholly attributable to the direct initiation of fellatio during menstruation.

† So also, animals which can hardly be credited with complexly symbolic “unconscious fantasies,” develop simultaneously or in succession such widely diverse “organ neuroses” as anorexia, respiratory tics, cardiac arrhythmias, colonic dysfunctions, sphincter incontinence, ejaculatio praecox and other sexual disturbances, and even ostensibly hallucinatory and delusional behavior, with the nature and durations of the symptoms being dependent not on the nature of the conflictual experience—which was held constant in the experimental work—but rather (a) on the species of the animal and (b) its individual metabolic vulnerabilities. See Masserman, J. H., 1968.

**CASE 31.** *Variability of psychophysiologic dysfunctions.* A 20-year-old patient, after a neurotic childhood and adolescence, began having functional gastrointestinal complaints which, after about four years, gave place to severe cardiorespiratory dysfunctions. These also disappeared spontaneously, but the patient became so obsessive-compulsive that, after six years, he was forced to seek analytic therapy. The details of his analysis are not relevant here except for the fact that during his therapy he not only recapitulated almost every previously experienced somatic dysfunction but combined them into configurations of bodily symptoms (e.g., dermatoses, syncopal episodes, migraine headaches, dysphagias) with or without concomitant alloplastic behavior, such as kleptomania, etc. Certain general formulations as to his character, of course, held true broadly, but in this patient, as in others, to have selected from the broad spectrum of the data and their multiple possible permutations a few phrases to dignify as specific or exclusively "psychodynamic" or "psychosomatic" formulas would have constituted a thoroughly misleading interpretation of the facts. Such considerations led to the following incident, here cited as a case illustration.

**CASE 32.** *The Psychosomatic Profile of an Ingrown Toenail.* Some time ago, when I was particularly bemused by problems raised in the preceding section, I was invited to lecture before a group of internists on the general topic of psychosomatic medicine. I accepted, in the hope that I could share my tribulations with my medical colleagues and we might thereby approach a clearer understanding. Let me here recount, in the briefest space possible, the story of that lecture and its almost incredible denouement.

I began my quite informal talk by pointing out that the Cartesian riddle of a triology of spirit, mind and body acting upon each other respectively through the soul and the pineal gland had been resolved by regarding such distinctions merely as differently conceived parameters of the same phenomenology, the "ultimate" nature of which was scientifically indeterminate. Thus, also in medicine, it was not a question of the interaction of "psyche" (soul) and "soma" (body), but of the simultaneous study of all determinable aspects of external and internal behavior—a concept that made the term "psychosomatic medicine" a double tautology. True, basic physiologic experiences could be elaborated into highly symbolic expressions. For instance, a sudden grasp and utilization of external reality could be actually accompanied by a quick inhalation and regarded fancifully as a "spiritual inspiration" (*spiritus* = air), as though it were analogous to a neonatal gasp; similarly, an attempt to retain the fantastically incorporated universe could be equated with retarded expiration and expressed in asthmatic respiratory disturbances. In the gastrointestinal sphere, also, longings for external substance could be accompanied by hypersecretion and increased peristalsis, symbolic riddance by colonic spasms, rage by increased musculoskeletal and vascular tonus, and so on through various other systemic manifestations. Such bodily participations were as demonstrable as the more obvious vasodilation in the cheeks in a blush for shame, or a cardiac arrhythmia during fear; indeed, a multitude of such psychophysiologic correlations could be marshaled into what might be called the dynamic physiology and economy of total behavior. Quiet different, however, was a recent tendency to become enrap-

tured in untrammelled flights of fantasy. Concepts thus engendered, may be engagingly poetic, but any resemblance they retain to scientific theorems are quite possibly seriously misleading. To illustrate this point in my lecture I proceeded to parody such *a priori* derivations by improvising a *Psychosomatic Formula for an Ingrown Toenail*.

Consider, I said, the toenail. Anthropologists have pointed out that man's brain developed when, due to the evolution of a strong pedal hallux, his arms were freed of the task of locomotion so that he could walk about the earth in an upright position, manipulating its resources and pondering on the cosmos above. But the toenail is more than the fundamental basis of intelligence; it epitomizes man's vital libido. Thus, it is the most protuberant part of the body, hard and rounded; in locomotion it prescribes a most suggestive to-and-from movement—obviously, then, it is a basic penile symbol displaced, for a change, downward. But let us also remember the anatomic origin of this important little phallus, namely, the *nail-bed*—also a most significant term. This in turn consists of an *invagination* of vascular tissues into a zone called, with intuitive propriety, the *stratum germinativum* or *matrix*—a region consummately feminine in its conformation, physiology and import. Here, then, we have a psychosomatically significant microcosm: a womb-equivalent ever generating a masculine imago which goes forth to establish the family, the clan, and thus a civilized social order.

But consider what happens when this essential functioning is disrupted by frustration and conflict, when, specifically, the erect nail is stubbed and traumatized or is too long opposed by unyielding reality in the form of a repressive shoe. Clinically and perhaps personally we know the effects all too well: the nail, particularly at the peripheral portions of its individuality or, in Freudian terminology, its *ego boundaries*, turns about and digs its way back into the flesh of its origin. Moreover, to those properly indoctrinated with psychodynamic understanding, a much deeper significance can be discerned in this process. It will appear, indeed, that the countercatheted ungual masculinity, blocked from its exteriorizing libidinal outlets, introverts upon itself and eventually even seeks final regression through the mechanisms of reencapsulation and vascularization—i.e., a return to intrauterine existence. This illuminating formula, derived as it is through semantic logic enlightened by psychoanalytic wisdom, could of course stand on its merits alone about as well as others derived from similar explanatory endeavors; fortunately, however, it can be further validated by objective clinical observation. Thus, it can be demonstrated that patients of both sexes with ingrown toenails actually do have both masculine aspirations and regressive fantasies, and the mere fact that patients without ingrown toenails have the same unconscious dynamisms serves merely to emphasize once again how the study of the abnormal can reveal profound truths about all mankind.

Here I ended my lecture on psychosomatics, rewarded by what I thought was an appreciative gleam in the eyes of most of my listeners and trusting that I had aroused a healthy whimsy of doubt about some of the verbal gymnastics that pass for serious thinking in the field. My optimism, however, was somewhat modified when, on meeting some of the members of the audience days and weeks later, I was actually congratulated on the clinical and analytic perspicacity with which I had

derived the specific dynamic formula for the etiology and possible therapy of that hitherto unexplained psychosomatic disorder—onychocryptosis or ingrown toenail!

It was I, then, who had been naive in so casting my lecture. I had not recognized how precious and ingrained was the Power of the Word and the Formula; how avidly even trained and intelligent physicians will cling to the belief that, if only they can evolve and repeat the proper incantation, bodily or behavioral disorders from alopecia to zoophobia can be magically exorcised and made to vanish on command.

#### **Clinical Criteria for the Diagnosis of Psychosomatic Disorders**

Although there are as yet no simple and constant formulae in this field, psychosomatic disorders may nevertheless be diagnosed with a fair degree of accuracy by the general characteristics of neurotic reactions previously noted in Chapters 2 and 3, and more specifically applicable as follows:

*Absence of Direct Organic Etiology.* From a negative standpoint, adequate investigation must reveal no evidence of primary congenital, infectious, traumatic, metabolic or neoplastic factors sufficient in themselves to cause the dysfunction. This must be true in retrospect, even though functional disorders may later cause not only histologically demonstrable and sometimes irreversible pathologic changes in the organ system first affected, but also secondary disturbances in other organs throughout the body as outlined in the section on Organic Complications below.

*Nonorganic Configurations.* Again negatively, the somatic disorder does not correspond semeiologically with known organic diseases; e.g., a functional analgesia of the hand may be so nearly absolute as to permit the patient to tolerate the burning end of a cigarette, and yet the anesthesia stops at the wrist (glove anesthesia) and does not correspond in effects and distribution to that produced by lesions of the radial and ulnar nerves.

Conversely, positive findings should indicate that the presenting symptoms were precipitated during some environmental or interpersonal crisis, that they had overt or covert adaptational significance, and that they are relieved when the conflicts are spontaneously or therapeutically resolved.

#### **Organic Complications**

Finally, whatever the etiology of the initial hypermotility and hyperacidity of a "gastric neurosis," it must be recognized that these physiologic disturbances may lead to the formation of a peptic ulcer, which then constitutes an independent pathologic process that can be only in-

directly benefited by psychiatric therapy. Similarly, neurotic hypertension may eventually lead to irreversible arteriosclerosis, or severe or repeated emotional excitements in a thyrotoxically susceptible individual may initiate a cycle of changes in the thyroid gland which then progresses independently to the full-blown expressions of a Graves' disease. Somatic complications may be clinically critical, as in neurotically exacerbated intermittent claudication leading to gangrene of an extremity, or even as dangerous as the occurrence of a coronary thrombosis or a cerebral hemorrhage in vascularly vulnerable individuals during a severe emotional disturbance. Such examples illustrate the importance of psychiatric factors in the etiology of organic illnesses, but emphasize even more strongly the necessity of adequate medical diagnosis and effective medical or operative therapy if tissue lesions impend or are progressive. There is no specialty whose practitioners can avoid dealing with the total behavior of a patient subsumed under the rubrics of psychosomatic medicine.

A channelization of repressed motor discharges into vasospastic phenomena producing the symptomatology of Raynaud's disease is illustrated by the following case:

CASE 33. *Raynaud's disease with psychophysiologic exacerbations (305.3).* A 32-year-old patient of Polish extraction applied to the clinics with complaints of (1) attacks of blanching, tingling and numbness of his fingers and hands for the preceding 8 months, (2) a generalized hyperesthesia to touch and to cold stimuli, and (3) widely distributed "muscle knockings," by which he meant localized, transient but painful regions of spasticity. The patient's history, as obtained from several sources preparatory to his admission to the hospital, may be summarized as follows:

His mother and all his siblings were described by every informant as histrionically volatile persons who passed readily in and out of deep grief, sudden, intense rages and other affective reactions under minor stresses. His sister was especially unstable in this respect and often suffered from eczema and other disorders, which persisted for weeks after a severe emotional upset.

The patient had a physically healthy childhood in a rural community and seemed to have been free of neurotic traits other than the mercurial temperament characteristic of his family. He had received only eight grades of parochial schooling and had cultivated no particular social or intellectual aptitudes. In personality, he developed into a hard-working, intense, perfectionistic individual, humorless, morally rigid, intensely religious and culturally limited.

When the patient was 17, his father—the only comparatively stable and placid member of the family—died, after which the patient, according to various informants, remained "grief stricken for two years." He continued to work as a factory laborer, but became even more constricted in his interests and permitted himself almost no contacts and recreations outside his church.

Sexually, he remained inhibited, inexperienced and naive until the age of 24, when, on the advice of a priest, he married a Polish immigrant girl of his own age.

Sexual relations were unsatisfactory, and his wife, finding him either unreasonably hot tempered or cold and remote, gradually began to seek interests outside the home. Four years later, she began having extramarital affairs and, in another year, left him. The patient considered himself disgraced in his community, gave up his job and went to Chicago to live with another branch of his family. Here, however, his readjustments proved difficult on a number of counts: he was socially more isolated than ever; his parish priest and local church were "too easy-going" to suit his desires for strict orthodoxy; he could not find steady work, and finally he had to depend for support on relatives who showed little inclination whatever to tolerate his rigid habits and unpredictable outbursts of rage and vituperation. Of necessity, he had to suppress these, but it was while attempting to control a particularly severe feeling of anger that the patient first experienced, about two years before his admission to the Clinics, the spasms and "muscle knocking" in his arms and shoulders.

The following winter his other principal symptom appeared; one day, after he had stalked out of his home to avoid an imminent quarrel with the cousin with whom he was living, he noted that although the day was relatively mild, his hands quickly became numb, blanched and cold, and could be restored to normal only by dint of considerable rubbing, warmth and rest. Such episodes occurred and increased in frequency throughout that winter and the patient, though he was aware that they nearly always were precipitated by emotional tension, began to fear he had some serious illness. To give substance to the latter explanation he spent considerable money on salves and patent medicines, refused to take even temporary work that exposed his hands to chilling, and so became even more dependent on his increasingly unsympathetic family. His "knockings" and "chills" improved the following summer, probably because the warm weather mitigated the organic contributory factors in his illness, but possibly also because his physician had waited for this as proof that the patient "really had Raynaud's disease." Now, however, the patient noted that his hands had become susceptible even to cool water and, when his symptoms grew worse in the succeeding autumn, he again quit his job and demanded that his family provide funds to send him to the Mayo Clinic because, as he put it, he had been a good man and a devout Catholic, and therefore deserved the best. However, both sides reached what they considered a compromise and the patient was brought to the University Hospital.

Routine physical, x-ray, urinary, blood chemistry, and cytologic findings were normal. Neurologic examination showed that the patient's complaints of "knocking" were occasionally accompanied by discrete myoclonic jerks in the affected muscles, and that these jerks could be recorded on a myographic tracing of the right triceps. However, neither the complaints nor the localized twitches were relieved by the intravenous administration of calcium gluconate as a test of their tetanic origin. Special investigations of the patient's vasomotor responses revealed the following: The control electrical resistance between the right palm and index finger in the absence of an attack was determined to be 90,000 ohms. The patient's hand was then submerged in water at 0°C. for 30 seconds, which brought on the white, after which a ring of blue ascended to the tip of each digit, leaving the area

behind first purple, then red. The subungual pulse vanished and the electrical resistance from palm to finger tip increased to 100,000 ohms. At this stage, the patient reported that he was suffering from a typical attack of "cold numbness" in his hands, which lasted 15 to 30 minutes. He was then requested to breath deeply and concentrate his attention on the examiner, and was put in a mild state of quasi-hypnosis, in which he was given strong suggestions that his hands would rapidly again become warm, relaxed and normal. Within two minutes the pulse reappeared, the hand turned pink and the resistance dropped to 63,000 ohms.

Observation on the ward confirmed the importance of emotional factors in precipitating the patient's myoclonic and vasospastic attacks. For instance, these symptoms occurred with severity during an electrical storm, when the patient became markedly excited because, as he explained to the physician summoned to see him, it awoke fears that dated from the time his home was demolished "by wind and lightning" when he was 10 years old; ever since, he could not bear to be alone in a room during even a shower. To check the possibility that barometric or electrical influences had played a part in the phobic reaction, the patient was again calmed and given gentle reassurances, with the result that his vasospasms were rapidly alleviated. Similarly, it was noted that attacks frequently occurred when the patient felt aggrieved and angered over some trivial neglect by the nursing or medical staff. His own description of these episodes was: "First I get to feel quite excited, then mad or blue over something that happened—then my whole body feels stiff and jerky, like I want to run or climb or do something, but most times I can't. . . . Then, if I get chilled or overheated, my arms and hands get numb. . . . but after the coldness is gone, I feel better all over and I'm not excited any more."

*Course under Therapy.* Two staff internists who specialized in cardiovascular diseases confirmed our impression that, whatever its complex constitutional, physiologic and neurotic etiology, the patient's present illness was indeed symptomatic of early Raynaud's disease. It was therefore recommended that he move to a warmer climate, but an especial effort was made to furnish the patient with some effective understanding of the role excessive indignation and suppressed rage played in precipitating his attacks, and of the consequent necessity of avoiding physical and emotional stress insofar as possible. A year later, however, he reappeared at the Clinics to report to the psychiatrist, on whom he had become demandingly dependent, that he found it financially impossible to change his residence, that his emotional difficulties had, if anything, been aggravated, that now the attacks of vasospasm had spread to his arms, feet and even the tip of his tongue, and that sometimes they were accompanied by transient syncope. Recheck diagnostic examinations showed some blanching of the optic disk, smoothing of the mucosa of the tongue, atrophic changes in the skin of the extremities, residual pitting edema of the legs, and x-ray evidence of early arthritic changes in several peripheral joints. A neurologist, called into consultation, bluntly advised the patient to have a series of "operations to cut the sympathetic nerves," and the patient reacted by a vasospastic attack of such severity that edematous gangrene of the extremities seemed threatened. Moreover, he refused further advice and left the hospital with the intent of traveling to Texas for permanent residence. Efforts to learn his subsequent course were not successful.

*Comment.* It is impossible to discount or neglect the physiologic susceptibilities to vasospasm in this patient, nor is it profitable to speculate, in the absence of control data, as to the course his illness might have taken had it not become neurotically aggravated by channelization of adrenergic stimuli into the vasomotor system. Nevertheless, the influence of neurotic factors was demonstrated, and the necessity for their recognition and control, as in all such psychosomatic disorders, was evident. Unfortunately, it seemed that by the time the patient applied for therapy the organic disease process had become irreversible. At first, then, meliorative therapy consisted in the avoidance of traumatic psychosomatic stimuli; later, the only recourse seemed to be surgical interruption of the sympathetic vasoconstrictor pathways. Yet, when this was proposed, perhaps without sufficient sympathy and tact, the patient interpreted it as still another threat of personal attack, which once again evoked his distrust of his fellow man. Unfortunately, this was now generalized to include all physicians, thus breaking the therapeutic rapport and permanently severing our contact with the patient.

*Clinical Stoicism.* The type of behavior just described, accompanying organically expressed but partially self-inflicted disorders, may be contrasted clinically with what appears to be a passive, almost indifferent attitude to the seriousness of an illness even in its terminal stages. This phenomenon has given rise to various medical clichés about the "euphoria" of the tubercular, the "stoic resignation" of the leper, etc. Actually, such patients are far from happy or even reconciled to their illness, but they must repress and deny their recognition of its seriousness or else dwell in unrealistic fantasy over their anticipated life after physical release. Sometimes this attitude creates a serious clinical problem, as in the following example:

**CASE 34. *Psychophysiologic exacerbations of renovascular disorder.*** An attractive 18-year-old girl was referred by her employers to the neurosurgical service with symptoms of headaches and syncopal attacks dating from a nephrectomy for atrophic kidney a year previously. The relevant diagnostic findings were: Blood pressure ranging from 170/120 to 230/140 at rest; liminal choked disks with hypertensive fundi; left axis deviation of the heart; plasma protein 7.51 mg per 100 cc; urea clearance 16.7; blood and urine normal. Malignant hypertension was diagnosed, but several internists and surgical consultants suggested neurotic or even psychotic factors in the patient's illness on the grounds that the girl, though obviously and pathetically ill, minimized her symptoms, seemed to care little as to whether anything was done for her, faced the seriousness of the then popular Smith-Wick operation with a seemingly jaunty indifference, and spoke unrealistically of "returning to work in a week or two." Psychiatric consultation was therefore requested and revealed the following:

The patient's parents had had a stormy marital life, terminated when the patient was 9 by her mother's death at the hands of a paramour. Both parents, nevertheless, had been devoted to their children, and the patient had shown no serious neurotic reactions during her childhood, had adjusted well to her father's remarriage and had grown into an intelligent, charming and popular girl. At the age of 11 she had begun to suffer from urinary disturbances and right lumbar pains which were later diagnosed as due to an atrophic and infected right kidney. However, surgery was not strongly urged, and the patient, despite her symptoms, preferred to continue her education, graduated from high school with scholastic and social success at 17 and immediately took a job at a local factory. Here her initiative and intelligence merited a series of promotions, but increasingly severe headaches and visual disturbances made it imperative that she have her kidney removed. Even more unfortunately, this operation did not correct the sympathetic imbalances that had already become established. Consequently, her blood pressure reached acutely dangerous levels and her physician insisted that she enter the University Hospital for a sympathectomy.

During the psychiatric interview the patient confessed that, in reality, she was very far from indifferent to the impending operation. On the contrary, she was filled with such deep anxieties that it took every effort on her part to suppress them "so that the doctors who have been so nice to me won't think I'm a big baby." These anxieties, unfortunately, had been increased by another hypertensive patient who had shared her room and who, jealous of the patient's youth and charm, had regaled her with tales of the sufferings attendant on "incurable high blood pressure," and the horror and, what was worse, the ineffectiveness of operations she herself had had. As a result, the patient, while pretending to sleep when she thought herself observed by the nursing staff, had spent entire nights speculating whether her body would be disfigured by operative scars, what limited outlets in work or play would still be possible for her, and whether the young man to whom she was engaged would really want an invalid for a wife.

*Course under Therapy.* As the patient unburdened herself to the psychiatrist, tears came, and with them evident and avid desire for comfort and explicit reassurances. These, of course, were given in repeated interviews with as much optimism as could be accepted and justified, and the patient's deep anxieties and painful pretenses of indifference over her fate were rendered less necessary. She thereafter cooperated in her surgical care excellently during the difficult period of a two-stage sympathectomy which, fortunately, reduced her resting blood pressure to 120/85. Following her discharge, the patient, after a prolonged vacation, herself broke the engagement (which she had previously accepted more out of desperation than for any other reason), returned to less strenuous work and made other social adjustments which, though necessarily influenced by her physical limitations, were more realistic and more satisfactory than her previous blind refusals to face her illness.

*Disorders of Integumentary Functions.* The skin, an organ that mediates many exhibitionistic and erotic experiences, is not only normally involved in these activities (blushing, caressing, etc.) but frequently is the

site of deviated sexual or aggressive expression, as may be seen in some forms of so-called "neurodermatitis" (cf. Becker, Obermeyer, Saul). Unfortunately the dynamic interpretations of this relationship have sometimes been elementary and the therapy has been confined to "explanations" bolstered by salves and sedatives—all occasionally in excessive amounts. One instance, with toxic-organic complications, is the following:

*CASE 35. Psychophysiological skin reaction with bromide and barbiturate intoxication (305.0/304.2).* A psychiatric consultation was requested for a 25-year-old married woman who had been admitted to the dermatologic service with complaints of a chronic pruritic eczema, complicated by a papular dermatitis that had appeared after she had begun to take large quantities of "nerve medicine" two months previously. On examination, the patient was found to be stuporous, disorientated and vaguely hallucinated; bromism was suspected and confirmed by two blood-bromide readings of 215 and 205 mg per 100 cc.

The patient was transferred to the psychiatric service where, after several days of forced fluids and suspension of all medication, her confusion and mild ataxia abated, the papular rash began to clear and the following history was obtained:

She was an only child of parents who seemed to take pride in being theatrical in every sense of the word, and who lived an erratic, footloose life of travel, mutual recriminations, separations, passionate reunions and histrionic scenes at home and in public. Left to herself, the patient had grown to take great pride in her slim, graceful body, had cultivated it with much training and exercise, and had delighted in displaying as much of it as permissible as a professional dancer. Sexually, she had been promiscuous, mainly because of the narcissistic pride she experienced in having herself fondled; in contrast, intercourse itself was an anticlimax, and the patient was orgasmically frigid. After many conquests, she had married a well-to-do man who professed deathless infatuation with her and who promised her complete financial security, freedom from the usual marital obligations and an untrammeled pursuit of her "career." Unfortunately, these promises had not materialized; instead, despite every contraceptive precaution, she became pregnant. The patient remembered the repugnance with which she watched her skin become blotchy and her breasts and abdomen enlarge, and her anguish at the thought that "maybe I'll lose my shape and beauty." Early in pregnancy, too, general pruritus appeared, and the patient began to rub and finally to scratch herself with imperfectly repressed thoughts of attacking her child through her own body. Her husband, however, would not agree to an abortion, and sensing his wife's continued rejection of the child after it was born, insisted that his mother come to live with them to care for it. Friction between the two women ensued immediately, and the patient's dermatitis became worse. In this connection, she remembered that for the first time she began to experience an almost masturbatory element in her pruritus; her scratching would reach an orgasmic intensity, followed by a kind of detumescence and relief. The patient consulted various dermatologists, who prescribed baths, lotions, and salves supplemented, after the birth of her child, by increasing doses of sedative prescriptions containing bromides and luminal for her "nervousness." These had finally

caused the complicating toxic rash and delirium for which she was admitted to the hospital.

*Course under Therapy.* With the cessation of bromide and barbiturate medication and the administration of sodium chloride solution, the patient's senso-rium cleared and her drug rash gradually disappeared. As is often the case in narcissistically introspective persons, a working insight was not difficult to establish; a far greater problem was to find an acceptable field of expression for attitudes that were scarcely less modifiable for being made explicit. A compromise was finally worked out: a relatively devoted governess acceptable to both the patient and her husband replaced the mother-in-law in caring for the child. The husband was made more cooperative in the arrangement by the tactful implication that, as he himself had realized before his marriage, he could not in any case force his wife into maternal duties; should he persist in trying, she might once again, quite unconsciously, try to punish him by impairing the beauty he still greatly admired. For her part, the patient also compromised: she applied for and won the part of a frustrated career woman in a television serial, and thus, while remaining with her husband and child in the public role of a devoted wife and mother, had a daily opportunity of identifying with her theatrical parents in a fervor of televised emotion that won her specialized audience's acclaim and her sponsor's financial gratitude. In a five-year follow-up, she reported that no further pregnancies, rashes or deliria had occurred and that she was quite happy in what she termed her creativity as a television artist.

*Exhaustive-Regressive States (Neurasthenia, 300.5).* The term neurasthenia was introduced into American psychiatry by Beard in 1869, and, since it was a euphonious appellation that implied a respectable organic etiology for various neurotic reactions, it became predictably popular with the profession and the laity alike. Even Freud, in 1894, grouped neurasthenia and anxiety neuroses together as the "actual neuroses," and attributed the former to "actual" exhaustion of the nervous system by masturbation. The term is now loosely applied to any ill defined syndrome consisting essentially of lack of energy, easy fatigability, indifferent appetite, sluggish mentation and emotional irritability, and persistent feelings of lassitude or boredom without fixed depression. Somatically there may be variable pulse, low blood pressure, irregular bowel function, low back pains, loss of weight and lessened sexual potency. Occasionally there are complaints of "headaches" described on closer questioning, as less a pain than a feeling of heaviness, depression or a ring-like constriction of the cranium.

Another fairly frequent form of the "neurasthenia" syndrome may follow periods of prolonged alertness and concentrated effort. Thus a writer, a physician, an engineer or a staff officer who has been applying his energies and capacities to the utmost in some major project may find that, despite feelings of exhaustion, and dissatisfied with his accomplishments. In

industry, this syndrome is recognized as "executive funk"; in a military setting, it may be miscalled battle fatigue, even when there have been no traumata connected with actual combat—or, more accurately and descriptively "old sergeant's syndrome."

As may be inferred, however, these reactions are manifestations of psychophysiologic depletion, due less to physical overwork than to prolonged but unrecognized internal tensions deeply repressed and sufficiently disciplined during the performance of the task itself, but eventually cumulative either to the point of exhaustion or else to sudden explosive expressions of blind fury at the social order which demanded such sacrifices. In more favorable circumstances the subject may resolve this tension by abandoning attempts at prescribed or self-enforced rest, and either turning the momentum of his energies into some new and diverting project, or else finding impetuous or turbulent release in a period of spree and dissipation. In therapy, mild sedation, high caloric diet and a restful environment rather than physical inactivity should be employed, preparatory to resolving the motivational impasse by mitigating the patient's resentments, remobilizing his latent energies and channeling them into activities more truly satisfying to himself. However, if the patient's behavior regresses to an inert, querulous invalidism, it is often necessary to deal more specifically with the covert anxiety, chronic mild depression and neurotic physiologic dysfunctions that comprise "chronic neurasthenia" on a more deeply characterologic level.

In review, it is evident, that none of the syndromes surveyed in this section represents any single clinical entity or category. On the contrary, the case histories may help clarify two major tenets of modern dynamic psychiatry: namely, (a) that *every* disorder of behavior is "psychophysiologic," and (b) that artificial categorizations are convenient for purposes of filing, but often hamper rather than aid our deeper understandings of human nature and its vicissitudes. Fortunately, it may now also be seen that the more fluid and dynamic approaches here illustrated, far from leading into uncharted confusion, actually simplify, help to define the field of study and facilitate rational and often effective methods of therapy.

### THERAPY OF PSYCHOPHYSIOLOGIC DISORDERS

Perhaps in no other sphere of human thoughts—except possibly in advertising, politics, and theology—are words used as loosely as they are in psychiatry. This curious kinship among four of the potent influences on human behavior is perhaps related to the fact that in all of them, words are sometimes employed to conceal the speaker's or writer's intent or igno-

rance, while exhorting the buyer, voter, disciple, or patient to do as the word user wishes. Trouble arises, however, when the speaker is carried away by his own attempts at verbal legerdemain and, like Dukas' sorcerer's apprentice, releases a flood of ambiguities that threatens to wash away recognizable realities until someone calls a halt to the engulfing torrent. Herewith some attempts at clarification:

*The Office of the Psychiatrist.* The word "office" obviously does not mean a purely geographical locale, since a physician will use essentially the same methods of treatment in his own or the patient's home, on the hospital ward or, for that matter, in any army ambulance or a space ship. Instead, the term connotes at least the following triplicate functions or *offices* of the physician *vis-à-vis* his patient's ultimate (Ur-) needs for physical well-being, social securities and metapsychologic serenity.

First, as a medical savant and technician, learned in theory and skilled in all the elaborate healing techniques of our modern age.

Second, as a concerned mentor and guardian dedicated above all else to the care and protection of his patients, much as a parent cherishes his hurt and helpless children whether or not they "deserve" or pay for it.

Third, and far from least, as a member of a potent secret order which, following ancient Asklepiad rites of apprenticeship, revelation and ordainment, is privileged far above other mortals to delve into the awesome mysteries of the body and soul (as in hypnosis or analytic "insights"), to work magic (i.e., by surgery or "miracle drugs") and to have semidivine power over life and death.

It is in these roles of idealized scientist, parent and necromancer that every physician is cast, whether or not he wishes to recognize this triune image nascent in every patient's hopes. More specifically:

*The Scientific Office:* Many patients expect the physician to be a savant with all modern scientific techniques and resources stored in his precision-machined fingertips guided by an instant-computer brain. He will be expected not only to have retained the presumably somewhat outmoded information he acquired in medical school, but also to have read every medical publication since his graduation (i.e., about eleven million pages yearly) including the up-to-the-breathless-minute revealed truths in authoritative sources such as *Time Magazine*, *Reader's Digest* and the Sunday newspaper supplements. It is, of course, tempting to reply to such unreasoned demands with a deprecatory denial, until we recall we, too, resent a television repairman who does not know every circuit by heart, or an automobile mechanic who cannot instantly diagnose and almost as rapidly repair a misfiring engine. Let us then understand that our patients, with infinitely more at stake, must ardently believe in our professional omniscience and omnipotence, and apply that insight to the following considerations:

*Our Professional Prestige:* Collectively and individually we must justify, insofar as possible, our reputation for erudition and medical skill. In this connection, we are therapeutically justified in having our diplomas and certificates modestly framed but fully displayed on the wall, and never consulting a medical book in the presence of a patient.

*Patient Reliance:* Each patient puts his primary trust in one doctor, to whom all other aides—laboratory technicians, nurses, radiologists and even surgeons—are regarded as assistants. It is, therefore, the inevitable responsibility of the patient's "private" physician, however much he would like to diffuse this responsibility through the "team" approach, to assemble and interpret all the diagnostic data to the patient, to visit him frequently if he is hospitalized, to be at his side when he is operated on, and in many similar ways to fulfill for him, physically when possible and psychologically always, the image of an all-caring, all-knowing parent for whom each of us yearns all the more ardently in sickness and travail.

*Iatrogenicity:* However, the physician must use his scientific prestige with full awareness of its power to harm as well as help. An overlong and seemingly overconcerned ophthalmoscopic examination may signify to our patient that we are gazing straight through the window of his brain at a cerebral tumor. A dolorous shake of the head as we fold the stethoscope after listening to his chest—no matter what is said afterward—may mean to him that our all-perceptive ears have heard the footsteps of approaching death. Indeed, serious iatrogenic illnesses with their full panoply of anxiety and "psychosomatic" dysfunctions may spring from tragically misleading communications between physician and patient, and some day may be justifiably considered as compensable as carelessly prescribed medication or a poorly performed surgical operation.

*The Parental Office:* Almost immediately beneath his adult facade every patient comes to a trusted physician as a hurt, hurting, and frightened child anxiously seeking a devoted parent; accordingly, he wants to be warmly welcomed, soothingly addressed and reassuringly touched, with intervening personnel, preliminary rituals and admission fees reduced to a minimum. Therefore, despite orthodox psychoanalytic strictures, it is still advantageous to greet patients politely, help old ladies off with their coats, and use an examining room equipped with a stethoscope, sphygmomanometer, and ophthalmoscope whenever indicated. Indeed, psychiatric trainees should be cautioned that, as long as they themselves act aloof from and possibly even afraid of their patients, they can hardly help the latter to understand and dissipate their own feelings of alienation, isolation, and remoteness from human fellowship. Instead, the first steps in the treatment of any patient are a prompt, individualized, sympathetic reception, a discerning anamnestic hearing and, when medically indicated,

that reassuring as well as informative interpersonal contact known as the physical examination.

*The Office of Wizard:* There is one more function that the physician must assume, though less overtly than the first two: that of priest and wizard. Our medical forebearers were trained in professional schools in the temples of Ra and Osiris, and we still carry as our emblem the serpentine staff which, long before it became the symbol of Aesculapius, was given by Yahweh to Aaron, physician-priest of the Hebrews. In the Roman tradition, we preface our prescriptions with a cross over Rx for *recipe*, representing a *prayer to Apollo, God of Healing*—a divinely wise and handsome progenitor, the image of all physicians, who taught the centaur Cheiron—a being significantly endowed, as all physicians also must be, with the head and brain of a man, and the bodily endurance of a horse. But whether or not our patients are aware of our celestial heritage, from the most overtly naive to the most professedly sophisticated they are covertly alike in one respect: our powers to serve them are wishfully presumed to transcend the mundane and include the esoteric and the mystic. Only God and the surgeon, often in the *reverse order of priority*, are trusted with one's helpless, ailing, bleeding body when life itself is at stake—an act of profound faith vouchsafed to no other profession on earth. But much more is covertly attributed to us: as anatomists we may secretly know the seat of the soul, and as physiologists we have recently let it be known that we have set up processes close to life itself. Nor are such preoccupations with the *mystique of therapy limited* merely to abstruse fantasies; on the contrary, they imbue the everyday warp and woof of medicine. Thus, all new antibiotics are heralded by manufacturer, advertiser, and public alike as “wonder weapons against disease”; similarly, merely changing a chlorine to a fluorine radical in the structural formula of a phenothiazine derivative purportedly makes it tomorrow’s “miracle cure of schizophrenia,” despite the long record of sad deficiencies in yesterday’s similarly acclaimed marvels. For that matter, such potions are not really needed: despite the fact that Bernheim, the most perceptive of students of hypnosis, concluded after long experience that “it is indeed a wise hypnotist that knows who is hypnotizing whom,” the public perennially insists on believing that by a combination of mesmeric passes and verbal incantations we can exorcise pain or command a hypnotized patient to secrete more insulin, heal his ulcer, relieve his childhood of actually change into another “personality.” Accordingly, we are vouchsafed secrets that only the priest can share, since, unlike the priest, we could in any case enforce a confessional by invoking our “truth serums” and mysterious black “lie-detector” boxes.

Unfortunately, there is also an obverse side: wizards are never above suspicion of using their powers as black magic for evil purposes. Zeus, who

through Apollo gave man the triple bounty of music, mathematics and medicine, also chained Prometheus for further promoting man's welfare; Cheiron, mentor of Aesculapius, on closer inspection could also be seen to have the hooves and tail of the devil; and even Aaron, Hebrew patriarch of physicians, was feared because he could spread plagues and slay the innocent first-born. Therefore, at any moment—as rising malpractice premiums show—the most revered Dr. Jekyll can be accused of turning into the most diabolical Mr. Hyde. But this shadowy background of ambivalent distrust that we all feel toward anyone accorded supreme authority over us brings into even sharper prominence the fact that, in order to work the miracles the public desires, we inheritors of the witch-doctors are endowed by our patients with thaumaturgic powers from which we cannot resign.

### Therapy

The word "therapy" itself is simply but profoundly derived from the Greek *therapeien*, meaning to serve—and "cure" derives from the Latin *curare*, to care. In effect, the physician *serves* by *medication* (a medium or mediator of the physician's concern and skill), by *surgery* (*chirurgery*, Greek—*Kheir ergein*, to work with the hands) or by other modes of treatment (Latin—*traetare*, our clinical treaties with our patients).

*Medicine.* No physician need minimize the solid advances we have made in immunology, deficiency diseases or scientific pharmacology; *psycho-somatically*, however, Lasagna can, under conducive circumstances, elicit greater analgesic effects from an injection of saline than from a grain of codeine, and Stuart Wolf can prescribe apomorphine as an effective antiemetic by implying to his eager residents, and through them to their trustful patients, that this was a new calmative synthesized at great cost for precisely that purpose. So also, Hardin Branch, H. K. Beecher, H. G. Wolff, and many others can repeatedly demonstrate that the efficacy of a drug, even on the most rigorous double-blind test, depends in a remarkably large part on the enthusiasm of the prescriber and the avidity of the recipient. The inferences are inescapable: every medication, in addition to its pharmacologic effects (if any), mediates a near-infinity of complex symbolic values and *transference transactions between the patient and the physician*. We must, of course, continue to use our metabolic supplements and alteratives as specifically as may be, but scientific *psycho-pharmacology* (L., *scientia—coordinated knowledge*) includes an understanding that what is mediated is much more than a chemical formula excluded from psychologic realities by a cork or a capsule.

*Surgery.* Nor are surgeons beyond similar reaches of illusion. There is perhaps no fantasy more deeply imbedded in antiquity than that disease can be gotten rid of by opening body cavities, nor is a more intimate contact possible between two presumably friendly people than that between patient and surgeon. Many a bronze age man has bequeathed to us his partly healed cranium in evidence of how readily he opened his mind to trepanation. Utilization of more readily available orifices by emesis, catharsis, diuresis, and diaphoresis has been practiced throughout the ages, and so has utilization of more incisive scarifications and phlebotomies. More directly in our own field, only a long generation ago, H. A. Cotton and others were claiming to cure psychosis by eliminating "foci of infection" through wholesale removal of teeth, tonsils, appendices, and a yard of colon. Today we generally deplore such maiming—and yet we continue to allow enemies of the human cerebral cortex to devastate it just as effectively by administering excessive electroshock to the point of semidecerebration. It is little excuse that many frightened, lonely people who employ hypochondria as their main mode of supplication for concern and help are willing to submit to—and may for a time feel relieved by—the most drastic forms of expiatory sacrifice and suffering, or that patients who would rather have their abdomens than their vistas opened may actually welcome hospitalization, surgery, and protracted and certified invalidism. Surgeons, too, must control their *furor chirurgensis* and, as curators of our patients' ultimate welfare, beware of the futility of waving scalpels as though they were magic wands.

CASE 36. *Experimental neuroses and therapy.* One aspect of dyadic "transferrential" therapy can be clarified by an experimental analogue—the retraining of animals that had been made neurotic by adaptational conflicts (cf. Masserman, J., *The Biodynamic Roots of Human Behavior*, 1969). Briefly, whenever the animal's previous experience with humans had been predominantly favorable ("positive transference") the experimenter could utilize this influence "therapeutically" or establish it anew. Thereafter, the most "neurotic" animal—even one huddled in cataleptic rigidity in a dark corner, or showing severe inhibitions, phobias, compulsions, "psychosomatic" dysfunctions, regressions and manifestly delusional behavior—might be led perhaps for the first time in months by gentle petting and coaxing to take food from the experimenter's hand. Once this initial receptivity was established the animal could be induced to eat from the floor of the apparatus if the experimenter's hand were held reassuringly in the cage; later it sufficed that the experimenter was merely in the room.

At any stage of this retraining the premature repetition even of a faint feeding signal would reprecipitate the conflict and set the animal's recovery back, perhaps irrevocably. However, if the experimenter exercised gentleness and patience and did

not at any time exceed the gradually regained tolerances and capacities of the animal, he could eventually induce it in successive stages to open the food-box, once again to begin responding to signals and manipulating switches, and eventually to reassert its former skills and patterns of self-sustenance. The retraining could then be continued to include acceptance of previously traumatic stimuli, so that at the end of the process the animals would welcome even an air blast or electric shock as itself a harbinger of food or other reward, and avidly work switches that administered these previously feared stimuli. After such patterns were in their turn reestablished, the experimenter could complete the therapeutic process by gradually withdrawing from the situation as the animal reasserted its self-sufficiency until his ministrations or presence was unnecessary.

To claim sweeping identities between the data of these experiments and the much more complex dynamics of clinical psychotherapy would be an oversimplification, and yet certain parallels need not be overlooked. For the psychiatrist, too, must be regarded as a helpful parent surrogate, else the patient would never have come to him. Armed with this implicit confidence (often explicitly denied) the therapist gently approaches the patient in his neurotic retreat, fills his needs personally insofar as practicable, and helps him to reexplore, retest and reevaluate experiential symbols and disruptive conflicts. This is done first in the therapeutic situation, then gradually—and never more rapidly than the patient's anxiety permits—with reference to the outside world, until the patient's relationships and transactions become properly concerned with persons and things that can play a favorable and permanent role in his future. Then, his task done, the therapist can relinquish his Virgillian role of guide and mentor as the patient takes his place once more in the world and no longer needs the psychiatrist except, perhaps, as another friend among a new-found many.

### **Psychiatric Therapy**

*In psychiatry, then, therapy comprises the optimum utilization of every medical, reeducative and social rehabilitative means at the physician's command to help the patient relinquish his previously neurotic patterns of behavior as no longer necessary or advantageous, while at the same time helping him to realize by subjective analysis, personal example, and progressive experience that more comprehensively adaptive and creative ways will be found to be on the whole more pleasurable and profitable. For this need not include primal screams or "unconscious motivations" over which the patient may decide he has no control; on the contrary, it is best that the patient soon learns to accept complete responsibility for all his actions. To cite an analogy: in treating diabetes, it is operationally irrelevant whether the "unconscious" actions of intracellular oxidases and the func-*

tions of the pancreas, or the "preconscious" and "conscious" regulation of insulin dosage and diet, are events in one or another spuriously segregated subdivisions of the psyche; all are interdependent and codetermined in a matrix of internal and external behavior. Finally, there is no dichotomy of "superficial" and "deep" therapy, since, in truth, the only distinctions that can be made in this as in any other branch of medicine are those between skillful and therefore effective treatments, as opposed to stereotyped, inappropriate—and therefore harmful or ineffective—methods of whatever brand, frequency or duration.

**CASE 37. *Pseudoanalytic interpretations.*** A psychologist in psychoanalytic training had long been troubled by eczema over his face and the upper part of his body. One day, while this patient was in an analytic hour, the therapist was called momentarily to greet a visiting celebrity in the outer office. On the therapist's return, the patient announced that his neck had begun to itch and that he had also had a series of associations which explained why. He had recalled that the eczema had first appeared on his scrotum when he was 5 years old at the precise time his only sister was born, and that his mother had permitted him to scratch as much as he wished. This, the patient said, had been an obvious Oedipal expression, much enjoyed in childhood. In the hour, he continued, a very similar thing had happened: the therapist had violated a maternal transference by diverting his attention to a rival, and the eczema had promptly reappeared on another phallic region "displaced upward"—the neck. Both symptoms were, moreover, doubly determined, since perhaps he had wanted also to get rid of the scrotum (and now the cervical phallus) in order to be female and helpless like his newly favored sister; also, the symptoms might represent a displaced self-castration for guilty anger at the therapist. The patient seemed much pleased by his own interpretations and rather disconcerted when the analyst made no special comment about these facile formulations.

Unfortunately, the cervical eczema, instead of disappearing after this "self-analysis," got steadily worse and the patient had to consult a dermatologist. At about this time, too, the patient was involved in an accident in which he smashed his automobile—another event he interpreted as "self-castration." When the therapist made no comment on this either, the patient became exceedingly anxious and demanded the reason for the therapist's protracted silence. The latter then commented simply that he had remembered seeing a papular rash on the patient's neck for several days *before* the incident of the visitor, and that, while the patient's fantasies about the events related to his eczema revealed his own dependencies, ready angers and deep jealousies, these attitudes were not necessarily specific for his dermatitis. After working this through a while longer, the patient came to a clearer recognition of what had transpired: he had indeed been jealous and had then offered the analyst a series of formulas derived from professional readings and discussions that he had thought would win not only the therapist's attention but also his admiration for the patient's "depth of insight." When this had failed he had added to the drama the incident of the car, although the accident itself had been caused less by "self-castration" than by the patient's bland assumption that a road always would

be cleared for his royal carriage. Finally, he began dealing with a much more significant series of fantasies: namely, that he had never been content to accede to the almost unanimous opinions of expert dermatologists that he suffered from certain food allergies and must limit his diet accordingly. Instead, he had clung to the notion that his dermatosis was "psychogenic," that he himself would find the "correct psychodynamic etiology" and that he could then master his handicap by a magic formula rather than by subservience to material necessity.

### Summary

The essentials of therapy, then, are these:

First, the maintenance of the scientific prestige, ethical integrity and social influence of the psychiatric and allied professions and the individual therapist. Differences of honest opinion, as in any mystic-scientific field, are acceptable; extreme claims, public polemics and transparent exhibitionisms diminish our status and thereby our capacity to help.

Second, the warm, unashamedly personal acceptance of each patient, not as another "interesting case" in support of some preconceived theory, or as an object of "accurate diagnosis," or even as grist for another therapeutic mill, but as a hurt, frightened and trouble human being seeking relief and guidance. These should be accorded him in the following ways:

The skillful utilization of every means available to relieve bodily pain and dysfunction, including medications with minimum undesirable side-effects or possibility of addiction.

The tactful and sympathetic exploration of the nature of the patient's motivations, the origins of his overt or covert symbolic representations and value-systems and the objectives of his characteristic patterns of behavior in relation to their interlocking advantages and disadvantages in the present and probable future. This exploration may be formal, minute and detailed (including, when indicated, "free-association," screen memories, dream material, and so on), or, more frequently, it may be confined to a careful and perceptive analysis of interview, psychological tests or other clinical data. In either case, the first objective will be *to help the patient recognize that his previous patterns of behavior were neither as necessary nor as advantageous as he had implicitly assumed them to be*. But to leave the patient here would be to place him in a new quandary: his former ways are no longer even delusionally effective, but he has not as yet learned new and better ones to take their place. It is therefore equally necessary *to utilize optimal transference situations and other therapeutic opportunities to impart the second essential portion of the dual dicta of insight, namely, that new patterns of conduct are really preferable—not alone because they are legal, moral or "mature," but because in the long run they will result in greater over-all satisfactions for all concerned*. Such reorientations, which

must be achieved without letting the patient become too regressive or dependent (i.e., "anaclitic"), may be rendered more effective by combinations of the following techniques: reeducation of the patient by the therapist through reason and demonstration, implicit or explicit personal example, and the utilization of every opportunity for progressive social participation. This may be encouraged and fostered through supervised "milieu" or "conjoint therapy" or as directly and indirectly arranged with the patient's family, friends, employer, or social group. Here, too, the deep influences of the patient's religious, political or other loyalties, instead of being attacked, may be used to their best advantage. Indeed, it is the eventual efficacy of all of these readjustments that determines whether or not the patient will be reaccepted as a happy and useful member of his society—and this in turn will spell the success or failure of the therapist.

More detailed descriptions and case illustrations of the principles and techniques here outlined for the therapy of the neuroses and subpsychotic behavior disorders will be included in a subsequent volume in this series.

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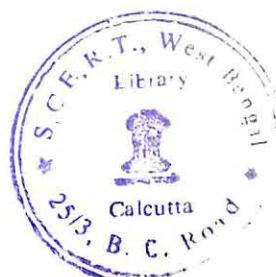
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## Chapter 7

### TRANSITIONAL ORGANIC-NEUROTIC-PSYCHOTIC REACTIONS

*Etiology.* As we have seen, disorders of behavior are caused by complex combinations of constitutional, organic, cultural and individual experiential factors, of which only a few are at present even partially analyzable. The etiology of any of these states is therefore manifold and can be approached at best only through a configuration of interrelated causal and contingent influences. We may here review briefly certain theoretical considerations as to the developmental and cultural determinants that partially differentiate the transitional disorders from related neuroses and psychoses.

#### TAXONOMY OF DISORDERS OF BEHAVIOR

Ontopsychologically, the position of the various psychoses and neuroses with regard to a theoretical fixation in or regression to successive phases of individual experience may be conceived as follows:

*Narcissistic Psychoses.* If the primary solipsism of the first months of infancy is nakedly re-evoked in or projected into later phases of personality development, the clinical picture is that of an autistic "schizophrenia" even though the content of verbal expression or other behavior consists of a filigree of quasi-communications and distorted interpersonal reactions derived from later experiences.

*Narcissistic Rebellion.* If the child, either through later familial neglect or overindulgence, is permitted to retain its primary delusions of omnipotence until these are challenged too late in life for effective modification, persistent, uncompromising self-assertion and intransigence, unmodified by experience, will result in a lifetime of obstinate, defiant or sociopathic behavior.

*Anaclitic-Depressive Reactions.* If, on the other hand, the essential early dependencies of the infant are seriously frustrated to the point of creating deeply ingrained conflicts of longing *versus* resentment in all interpersonal relationships, comparable deprivations in later life will precipitate reactions ranging from anaclitic depressions to agitated melancholias, possibly of psychotic intensity and pervasiveness.

*Ambivalent Compliance.* In contrast, if harsh discipline is instituted too early, as in overstringent weaning (oral) or bowel (anal) training, the child will performe learn external compliance, but later (a) may fear many situations in which it again feels its security symbolically endangered, or (b) in covert rebellion, make a travesty of conformity by carrying the latter to absurdly phobic-compulsive lengths of meticulousness and invariant ritual, (c) use these travesties of conduct as a mode of revenge against the very disciplines with which they seem to comply, (d) again fear reprisals for such covert aggressions, thus generating new anxieties which (e) require more obsessive-compulsive defenses, accompanied by new hatreds and aggressive overreactions, thus completing the vicious cycle. Because of such sequences, most such patterns are progressive and exceedingly difficult to treat. It is in this form of neurotic aberration with which we shall deal particularly in this chapter.

*Socialized Dysfunctions.* For the sake of completeness, we may here place the more severe anxiety-depressive-schizoid states and their various accompanying neuromuscular ("hysterical"), internal organic ("psychophysiologic") and serious personal, sexual, and social dysfunctions.

These five spheres of conflict correspond roughly to what in psychoanalytic terminology would be called respectively (1) narcissistic, (2) oral dependent, (3) oral aggressive, (4) anal and (5) regressions from Oedipal phases of libidinal development. However, the correspondence is only partial and the reactive character formations described above, though of broad import, are not to be taken as etiologically specific or mutually exclusive.

### CULTURAL DETERMINANTS

In its formative experiences the child not only faces the considerable task of adjusting to the demands of the physical universe but also must interact with its parents and nurses, and later with its teachers, colleagues, employers and other mentors, each of whom is a different bearer of his culture. We must therefore understand all behavior both in its physical and socio-cultural setting, for it is a striking and valid aphorism that there is hardly a form of conduct regarded as deviant in one society that would be considered not only "normal" but even commendable in another.

In our culture, we have developed codes of professed mores and prescribed action quite as rigid as those of "primitive" societies (Roheim, Mead), and yet on the whole less effective in endowing us with adequate securities; to paraphrase Thoreau—life for many is still "a quiet desperation."

The solution of this dilemma sought by many is often a patterning of thought, word and deed sterile or rigid enough to conceal conflicts of motivation, uncertainties of goal and ambivalences of relationship. Very early in life we begin to acquire and cling to ordered social habits: how to dress, to the last detail of the proper knots in our shoelaces, how to arrange and hold our eating utensils, what to learn and what to believe, how to express our thoughts within a rigid usage of language, form and cadence, and our feelings by prescribed mimetics (A. Scheflen), and so on to the minute details of our existence (see Case 7). If we deviate from this routine even to the extent of daring to go nude when alone in an isolated backwoods cabin or essaying to shave the "wrong" side of the face first in the morning, we may experience a vague, formless but troublesome anxiety. Moreover, as Anna Freud has pointed out, during periods of cultural accentuations of internal conflicts—as for instance during the exacerbation of erotic guilts at puberty—obsessive-compulsive behavior becomes more pervasive and insistent. Thus, it is a common sight to see adolescents stepping meticulously only on alternate cracks in the sidewalk, dressing only in the currently prescribed "informal" fashion, interlarding their speech with the accepted circumlocutions and the allusive catch-phrases of the season, or indulging in other mannerisms which, though intended to flout the conventions of their elders, are nearly always as stilted and stereotyped as the mores against which they presume to rebel. Similarly, the young wife, torn between attachments to and resentments of her firstborn child, may subject it to an unnecessarily rigid or even harmful schedule of bathing, dressing, feeding and "bowel training" until her ambivalences have been partially resolved. So, too, in other periods of emotional stress, human beings may react with an accentuation of obsessive ritualism in nearly every familial, occupational, social and religious sphere of behavior, and yet do so within the accepted norms of our culture.

The following case illustrates the highly complex role that organic and cultural factors may play in the etiology of anxiety states accompanied by "quasi-hysterical" reactions and obsessive ruminations of psychotic depth and intensity.

CASE 38. *Obsessive-compulsive and psychotic symptomatology with organic etiologic factors (pancreatic adenoma causing hypoglycemia (DMS II 294.0).*

*Presenting Complaints.* A 29-year-old housewife entered the clinics with the presenting complaint of extreme fear of being left alone lest she might "faint and die." She had therefore become exceedingly preoccupied with knowing exactly where every member of her extensive Greek family was at any given moment, and how they might all be summoned immediately, as is the custom among Greek "in-groups," if need should arise. Accompanying this was an obsessive-compulsive concern that her pantry and refrigerator be well stocked, ordinarily the accepted

duty of a Greek mother to ensure that her family would be in no danger of starvation. However, when her concerns became irrational, the family brought her for psychiatric care without the intermediation of a medical consultation.

The patient was admitted to the hospital, where further inquiry revealed that she also suffered from recurrent temporoparietal headaches, hypersomnia until late morning hours, diminution of initiative and energy, and attacks of sudden weakness, chills, sweating, palpitation and clouding of consciousness with partial disorientations for time and place. The first of these attacks had occurred six months previously and had been accompanied by a vague impression of a voice saying, "You are going insane." Four similar episodes, the last with agitation and screaming, had recurred at about monthly intervals, each after later morning awakening and before the patient had taken food. The intervals between the first three attacks had been relatively free of symptoms, but in the three months preceding admission the patient had become forgetful, slovenly, irritable, hyperemotional and increasingly subject to prolonged periods of lethargy and weakness. Six weeks before admission, in one of her sudden faints, the patient had fallen downstairs. On awakening soon after the fall, she developed first a spastic right hemiplegia, then a flaccid paralysis of the right leg, then complete aphonia. Within three hours she again became unconscious. A local physician diagnosed a "stroke," but since the patient awoke late the following morning completely free of symptoms, this diagnosis was changed to "hysterical paralysis."

*Past History.* The patient, a Greek immigrant at the age of fourteen, had been raised in an unstable familial and economic environment, and her education and cultural development had been limited. Several informants characterized her as having always been stubborn, impulsive, volatile and subject to severe temper tantrums when crossed. Her marital life had been stormy, and so frequently punctuated by episodes of pouting, silence or physical complaints that her husband had been sure that her present illness, too, was "just nerves."

*Status on Admission.* The patient was a well developed, apparently well nourished woman, whose only abnormal physical findings were dental caries, pyorrhoea and a mild papular rash which cleared when the patient's intake of a bromide-containing patent medicine was discontinued. There was a moderate, bilaterally equal accentuation of the deep tendon reflexes, but no residual neurologic signs of hemiplegia. The patient was generally apathetic, drowsy and noncommunicative, especially in the morning, with obvious defects in memory, grasp, flexibility, imagery and capacity for abstraction. A Binet test done two days after the patient's admission scored an I.Q. of 62.

*Laboratory Studies.* Despite the fact that the referral diagnosis of "hysteria" seemed partially confirmed by the patient's neurotic personality traits, her symptomatology suggested the possibility of a cerebral lesion or a recurrent hypoglycemia. Studies of the spinal fluid and visual fields showed normal findings, and the basal metabolic rate was reported as minus 6. In view of the possibility of a pituitary or hypothalamic lesion producing the Temple Fay type of automatic epilepsy, as described, the patient's ranges of blood pressure and temperature were observed closely, but no significant deviations in the diurnal pattern were found. For the same reason, x-ray studies were made on the sella turcica, but these showed normal

dimensions, and no evidence of corrosion of the clinoids or pituitary fossa was found. Pneumoencephalography indicated some diffuse cortical atrophy, but an excess of air may have been injected. The electroencephalogram showed considerable irregularity and arrhythmicity, some diminution in the normal frequency of alpha waves (8 to 12 per second) and an occasional delta wave (1/2 to 2 per second) over the frontal regions, but these findings were not definitely abnormal and could not be focalized.

Studies of the patient's blood chemistry were then undertaken. The serum pH,  $\text{CO}_2$ , proteins, cholesterol, nonprotein nitrogen, chlorides and amylase were within normal limits, but the dextrose content under varying conditions was pathognomonic. The fasting blood sugar ranged from 45 mg per 100 cc to as low as 18 mg and capillary sugars measured before meals thrice daily for six days ranged between 34 mg and 86 mg per 100 cc, with a mean of 48 mg. After the oral administration of 60 gm of dextrose, the content of her venous blood rose from 45 mg per 100 cc to 76 mg in 1 1/2 hours, after which it dropped back to 38. When the test was repeated with 25 gm of dextrose intravenously, the blood sugar rose from 40 mg per 100 cc to 208, but within 5 minutes began to drop, and at 90 minutes was at 35. On another occasion, when the patient was given 40 units of insulin, her capillary sugar dropped rapidly from 52 to 32, and had not recovered its former level at the end of an hour. During this period she showed dyskinetic movements and pallor, cold sweating, tremors, pounding pulse, ataxia and was disoriented and semiconscious. On a later similar occasion, intravenous saline had no effect, and exercise exacerbated the symptoms; conversely, an intramuscular injection of 1 cc of 1:1000 epinephrine produced as dramatic—though in this case less persistent—an improvement of the patient's condition as had the intravenous administration of dextrose. Finally, a roentgenologic study of the gastrointestinal tract revealed an externally imposed deformity of the duodenal bulb and thus completed the indications for a surgical exploration on the presumptive diagnosis of a pancreatic adenoma.

*Operation.* On laparotomy, a small, rounded, purplish mass 3 cm in greatest diameter was removed, together with a portion of the tail of the pancreas. Later examination showed the mass to be a benign but actively secreting islet-cell tumor.

*Course.* The patient developed a pancreatic fistula on the second day, but this uneventful. Capillary blood sugars taken thrice daily before meals for six days after the laparotomy ranged from 129 to 383, then dropped to high normal values. Glucose and insulin tolerance curves two weeks after operation showed normal reactions. The patient remained cheerful, cooperative and free of her former disturbances of consciousness; moreover, a recheck I.Q. was graded at 90. After her discharge home, some of her neurotic characteristics again became evident, but there was no return of the specific symptomatology that had occasioned her hospitalization.

*Comment.* Rennie and Howard, Conn and others believe that mild hypoglycemic reactions can occur on a purely "psychogenic" basis, although in such cases the blood sugar does not fall below 50 mg per 100 cc.

Romano and Coon have summarized other literature on the subject, and reported observations of their own. The case history cited here, however, illustrates fairly well the necessity of a sound medical orientation in dealing with all problems of behavior. Certainly, had all the patient's neurotic or psychotic aberrations been too readily dismissed as "merely functional"—an exasperatingly tautologic term—very serious errors in diagnosis and therapy would have been made. Nevertheless, even after the organic disturbances had been partially corrected by the surgical means employed, therapy was still necessary for the patient's other reactions to her illness. Significantly, despite her culturally ingrained responsibilities as a Greek mother (G. Vassilou), her fears of straining her family and the need for their protective presence diminished rapidly with the subsidence of the episodes of hypoglycemia, the imminence of which, through some unknown inner perception, the patient had apparently sensed. However, her tendencies to escape into imagery and her regressive infantisms proved, as might be expected, more refractory to therapy, especially as handicapped by her limited intellectual and general adaptive capacities. Fortunately, sufficient superficial reeducation could be accomplished during her stay in the hospital that, with her organic stresses removed and the expectations of her family lessened, she could be returned to the care of a competent family physician, under whose informed guidance she was able to make favorable progress.

### PSYCHOTIC TRANSITIONS

As we have seen, a compulsive act is one performed in obedience to an obsession or phobia on pain of anxiety should the act be omitted. The patient recognizes his acts as abnormal, but professes to be unable to resist them. However, they may become so persistent and bizarre as to reach psychotic levels, as illustrated in the following case:

*CASE 39. Severe obsessive-compulsive reactions with schizophrenic resolution.* A 28-year-old girl was admitted with the complaints that (a) she could not get rid of persistent ideas that she "must not eat," was "going insane" or was "turning into a dog," (b) that she had become unreasonably afraid of children and small animals, and (c) that she had developed various peculiar "habits," such as scrubbing her mouth out so often that the tissues were raw and bleeding, picking at her hair until she was almost bald and, more lately, holding onto a table and kicking both legs backwards. It was at first quite difficult to secure a coherent psychiatric anamnesis from any informant, but as reconstructed from all available sources, the development of the patient's disorder could be traced in the context of her life history approximately as follows:

The patient was one of four sisters, who (so they stated) had been greatly attached to each other in early life because of their mutual devotion to their mother—a person who, according to them, existed only to serve her children. The patient had done poorly in her studies, but had managed to get through high school because of her conscientious attendance, her reliability in performing minor tasks and her generally punctilious correctness and politeness in relation to her superiors. However, these characteristics had made her less than popular with her schoolmates, and she formed almost no social contacts outside the family circle. Unfortunately, too, the patient's mother died soon after the patient graduated from high school, and the father, who had long considered himself unwanted by any of the women in his house, promptly remarried and moved away.

The patient, after months of deep mourning for the mother, transferred all her dependence to the eldest sister, an intelligent, capable but unstable girl, and went to live in the latter's apartment. The sister, however, in overreaction to her previously strict compliance with maternal discipline, began to have affairs with various men, so that the patient once again felt displaced and homeless. In search of companionship and security, and naive in sexual matters, she, too, tried promiscuity for a time, became pregnant and unwillingly married the father of her child. Her husband at first tried conscientiously to make a success of their marriage, but was soon alienated by the patient's indecisiveness, her lack of personal warmth and her unending preoccupation with the trivialities of household detail. Moreover, although the patient spent much care and effort in feeding, dressing and training their daughter "properly," the husband sensed that the strict routines and increasingly severe discipline imposed on the girl were expressions of the patient's repressed hostilities toward both him and his progeny. He therefore tried to compensate by especial favoritism to the child and avoided having more children by employing the only method of contraception he thought permitted by his religion—sexual continence. The patient, though herself frigid, preferred to regard this as a deprivation of her rights and reacted with excessive sexual demands and obsessive-compulsive patterns of preparation for intercourse more and more openly charged with aggressivity; whereupon, the husband completed the vicious cycle by seeking interpersonal warmth and sexual relationships extramaritally. On one occasion when the patient was presented with unmistakable evidence of his "unfaithfulness," she reacted with an episode of extreme anxiety, followed by a peculiarly depersonalized "ocular conversion symptom": her child, her husband, her home, and finally everything about her appeared small (micropsia), as though displaced into the far distance. She was taken to an ophthalmologist who could find no signs of ocular disease, but told the family that such symptoms sometimes occurred as the "first signs of a brain tumor," and that the patient should have a complete neurologic examination. The neurologist consulted found no evidence of an organic lesion, but the patient had already reacted to the iatrogenic "trauma" with persistent fears that she was "going insane from brain disease" and, significantly, insisted that her child be taken care of by others to protect it from possible "insane impulses" on her part. It was at this juncture that her fears of being left alone with children or animals appeared, although the significance of the latter phobia was not made evident until later.

*Preliminary Adaptations.* The progress of the patient's neurosis was halted for a time by another development. She became exceedingly religious, and found great surcease in the rites and ritual of her Church, especially in long confessional in which she pleaded for and received forgiveness for "evil thoughts about my dear ones." During this interval she also sought to reestablish feelings of intimacy with her sisters, especially the eldest, with whom she tried to spend hours talking about the fondly remembered virtues of their mother. Nevertheless, after several months these comforts also failed (partly because priest and sister tired of her excessive demands), and from then on her deterioration was rapid. She developed a habit of kneeling repeatedly at home as though in silent prayer, yet instead of worshipful or beseeching thoughts or words she mumbled vague, stereotyped formulas of doubt and reproach. Finally, various other compulsions, such as continued douching, mouthwashing, picking at her hair (trichotillomania) and backward kicking, appeared in rapid succession and occasioned the patient's admission to the Clinics.

*Mental Status.* The patient presented a difficult custodial problem, since she refused to rest or sleep adequately and spent much of her time plying nurses, interns, other patients or even their visitors with the stock question: "Why do you think I can't have the right thoughts about Mr. ——(her husband) and Ann (her daughter)?" Each time the patient did so she would promptly apologize profusely and then repeat the question. She ate sparsely and only with much urging because of the insistent idea that food would cause her hair to grow "like animals" and that eventually she "might turn into a dog." Similarly, any attempt to feed her by tube, keep her from pulling her hair out or to confine her compulsive movements by the use of a cold pack or a continuous bath promptly induced such wild and pathetic anxiety that these procedures had to be discontinued. To give her some measure of rest, therefore, she was kept under Sodum Amytal narcosis for several days and fed, conversed with, and given whatever reassurances seemed indicated while semi-conscious.

It was during this period that the patient revealed some of the interrelationships of her phobias, obsessions and compulsive acts. For instance, she recollects that when, during one of their quarrels, her husband had finally become exasperated and called her "a bitch," this had precipitated specific fantasies such as the following: She admitted to herself that she was "like a bitch," since, in her sexual deprivation, she had wanted to become as promiscuous as she had been before her marriage. Since this was "dirty" and "like an animal," she had felt impelled to keep herself physically clean by continuous washing. To counteract an irresistible impulse to kick her legs out backward "like a bitch chasing away dogs"—a compulsion which, incidentally, made her husband regret his angry comparison—she had felt impelled to tear the hair of her head and body out by the roots so that she "would look as little like an animal as possible." While recounting such fantasies the patient would often berate herself "for making so much trouble for my good, good husband and my sweet little girl"—but at the same time she would unconsciously reveal her covert gratification in such thoughts by her gestures and facial expressions and by the interminable detail in which she persisted in describing, one by one, the supposed sufferings she had caused her sister, husband and child. Almost invariably, too, she would end this account by deplored her in

exorable fate, "I'll be put away to a mental hospital," and yet even here it was evident that, while this meant to the patient some punishment by deprivation and confinement, it also meant an intensely desired escape into a fantasized haven of regressive irresponsibility and dependence.

*Course.* Because of the patient's uncontrollable conduct it was found impossible to keep her in the general hospital and, with her family's ready consent, she was committed to a state institution. Here much of her restlessness and compulsive behavior abated and at the end of several weeks she fitted in so well with the routine of the institution that it was decided to parole her home. Her symptoms, however, reappeared in their original severity almost overnight, and within two days she also became definitely hallucinatory and delusional; e.g., she saw and heard animal-like figures who threatened her sexually, she felt herself "turning into a dog from the waist down," etc. On her return to the state institution she was given eighteen electroshock convulsive treatments which were eventually successful in controlling her acutely psychotic behavior, but the patient became so slovenly, amnestic, lacking in initiative and mentally defective that permanent custodial care eventually became necessary.

*Comment.* Even the limited data recorded show almost unmistakably the channelization of the behavior patterns of a "ritualistic personality" into those of a severe neurosis in which interrelated phobias, obsessions, compulsions and "psychosomatic" dysfunctions (e.g., micropsia, anorexia) involved animistic sexual, social and religious symbols, eventually expressed in schizophrenic behavior as the patient became increasingly regressed, isolated, fantasy-ridden and dereistic.

*Effect of Iatrogenic and Other Traumata.* A question of general significance may be raised in this connection: what role did the apparently incidental and superficial comments of the ophthalmologist play in this patient's neurosis? Obviously, they could not have been the determinative etiologic factors, since the patient's characterologic deficiencies and her neurotic and psychotic tendencies and susceptibilities dated from her early childhood. Nevertheless, if he had not suggested the presence of a "brain tumor," or if the husband had not used the specific term "bitch," would the content of the patient's neurosis have been different? In general, the latter question may be answered in the affirmative, but this answer must be qualified by several considerations. In the first place, the actual occurrence of such "traumata" is often questionable, since the history is often distorted by the patient or her family to "blame" a chronic neurosis on some relatively trivial external event. Second, such "events" often consist of the patient's *misinterpretations* of only a casual occurrence or a passing remark. Third, even when definite traumata do occur, they can be seriously pathogenic only if special sensitivities and aberrant proclivities are already present. This, of course, does not relieve any physician from the responsibility of recognizing these tendencies in his patient, and avoiding their

exacerbation by careless or alarming comment, inadequate handling of the transference, or other errors of psychiatric insight and technique.

*Therapy.* It is also apparent that by the time the patient was admitted to the Clinics her behavior had become quite rigidly channelized and, despite her verbal "insight," not easily amenable to the usual forms of short-term therapy. There was little choice but to permit her to regress into a routine, protected institutional life in which, as her anxieties diminished and opportunity permitted, consistent attempts could be made to make less necessary her obsessive-compulsive and fantastic defenses and to recultivate other realistic adaptations. Unfortunately, she was discharged from the state hospital before these readaptations could become stabilized. When her conflicts were reactivated at home, she therefore experienced so great a return of anxiety that all her former patterns were reprecipitated and, in addition, an acute schizophrenic reaction developed. These were in some degree disintegrated by the effects of shock therapy, but the net apparent gain was only to simplify in some measure the patient's permanent custodial care.

A case illustrating a rich combination of hysterical, phobic and compulsive symptoms, again with transition to depressive and schizophrenic behavior, is the following:

**CASE 40. *Psychophysiologic and affective disorders with schizophrenic channelization.*** An 18-year-old girl was referred from the otolaryngology clinic because no organic reason could be found for her complaint of a constantly "dry and gravelly" throat which had made it impossible for her to swallow solid food during the preceding two months. The physical findings were completely normal except for a mild degree of undernourishment and secondary anemia.

On inquiry, the patient readily confided that she had many other physical complaints, such as blurred vision, "bad stomach," insomnia and general muscular weakness. But her nonphysical ones concerned her even more: an abhorrence of gasoline-like odors, "which make my heart jump and I feel scared and like fainting," a fear of storms and of enclosed spaces, marked anxiety in heterosexual company, a conviction that she must never marry because "my children will be like me," and a growing melancholy with feelings of unworthiness, hopelessness and suicidal preoccupation. The patient was hospitalized and the following additional history obtained:

She remembered her early childhood mainly in terms of frequent "storms" between her violently quarreling parents. The patient herself was highly partial to her father, and her recollections of him were tinged with an aura of dependency—"a Jewish daughter always honors her father," and later, of almost overt eroticism. She remembered that when she was 8, she had suffered an attack of Vincent's angina with persistent sore throats for which, at the cost of the family's savings, her father—a house painter of limited means—had taken her directly to a famous and

expensive clinic. Moreover, she could clearly recall the pleasure she had taken in "scrubbing dad's back with gasoline to remove the paint caked on it," while he was taking his weekly bath.

At about the time of her menarche an episode occurred which, while probably retrospectively embroidered in her current fantasies, seemed to indicate that schizophrenic tendencies were already well established and needed only relatively minor toxic and symbolic stimuli to find direct expression. The circumstances were these: One day the patient, after "accidentally" spilling some paint on herself, decided that she, too, needed to clean herself with gasoline, and actually bathed in about a gallon of the fluid. She became confused, extremely frightened, ran into the street nude and there saw a vision of a patriarchal God, with features like her father, coming to crown her Queen of the Universe and commanding her to call "all women for judgment." Her acute fears abated within a few hours, but she entered into a mute fugue-like state from which she could not be aroused for two days. No further hallucinatory episodes occurred, but she developed a series of compulsions, among them a desire "to touch everyone gently so that they would know that I really don't want to slap them."

Despite such deviant behavior, she managed to complete high school and work several months in a bakery before the onset of her present illness, the precipitating circumstances for which were these: Six months before her admission to the Clinics she had found a condom in her father's pocket, together with other evidence that he was conducting an extramarital liaison. Inasmuch as (with little justification in reality) she had until then preferred to regard her father somewhat as an unappreciated saint, this discovery precipitated much brooding and bitter disillusionment, during which she resolved vaguely that, if there were no virtue in the world, she, too, might as well dispense with her hitherto severe sexual inhibitions. Significantly, the person she selected for her adventure was her employer at the bakery, an elderly married man with few scruples about resisting her naively expressed invitations. The seduction, however, was completely unsuccessful; her intended partner proved flaccid and, failing vaginal entry, suggested mutual exhibition and fellatio. At these suggestions the patient, who had been in a semi-trance through the episode, entered into a state of dreamlike depersonalization from which she "awoke" only after her employer, himself almost in panic, had brought her home with the explanation that she "had begun acting crazy and then fainted." A physician was summoned and "roused" her with an inescapably strong whiff of ammonia. After this the patient complained only that she had suddenly gotten "very sick" and that now her vision was blurred, that she could not open her mouth and felt very faint and weak. These symptoms gradually improved under a regimen of bed rest, "nerve tonics" and injections of vitamins administered daily with utmost gravity by her physician, but the "dry throat" and dysphagia persisted, and it was for these complaints that she was referred to the Clinics.

*Course under Therapy.* The patient demanded almost continuous attention on the ward, particularly from the senior attending psychiatrist, whom she would summon at odd hours "to tell him something else that's important." Actually, the history as outlined above was quite readily obtained with little or no questioning, though considerable unraveling and piecing was necessary because of the patient's

wanderings, her profusion of fantasy and her avid preemption of time and interest. Despite this garrulity she presented a picture closer to the usual conception of a depression: melancholic facies, prolonged, apparently unprovoked crying spells, slow movements and the somatic accompaniments of anorexia, constipation and oligomenorrhea. Initial therapy consisted of sedation, prolonged warm baths, high caloric feeding and frequent interviews directed mainly toward measured exploration, catharses and a growing security in the transference relationship. In these interviews, astonishingly frank "insights" appeared spontaneously; for instance, the patient equated her "fear of storms" with anxiety over parental quarrels and her claustrophobia with recollections of being confined in the bathroom with her nude father. Similarly, she associated her dysphagia directly with a "horrible impulse" she had experienced "to bite Mr. ——'s (her employer's) penis off when he had suggested fellatio. Within two weeks the patient showed considerable improvement in mood and self-control; concurrently her appetite returned, she ate solid food (although, significantly, she avoided meat), her vision cleared, she slept better and regained a fair amount of energy and initiative. Arrangements were then begun, with some help from the family, for whatever extramural readjustments might prove possible, and the patient was led to plan for a change of job, enrollment in properly supervised and nonthreatening social activities at her local synagogue and its attached clubs and attention to adequate diet and personal hygiene. After two weeks of further improvement the patient, though still covertly obsessional on topics of sex, was free of physical complaints. Since there seemed to be no purpose in further hospitalization at the time, she was discharged—although, for reasons that will be discussed, with a poor prognosis.

Our pessimism in this respect at first appeared unjustified, since the patient for a time seemed to adapt better in her familial relationships, worked steadily as a filing clerk in a small office and even cultivated a limited number of friends and social outlets under the gentle guidance of an elderly rabbi whom, of course, the patient immediately venerated as a new embodiment of all virtue. However, a year after her discharge another and this time apparently quite minor sexual temptation precipitated a return of visual and gastric disturbances, and a mild fugue-like state. Unfortunately, the patient was not returned to the Clinics, but instead was taken to a nonmedical self-styled "hypno-analyst," who treated her by daily hours of "free association" under hypnosis. Within two weeks the patient was actively hallucinated and delusional; she was convinced she had killed her father, whom she now saw as the Avenging Angel, and felt her "insides running out of her vagina." The patient was committed to a state hospital and six months later, during a parole period at home, committed suicide.

*Comment.* It may be noted that the earliest schizoid manifestation was related to a wide variety of hysterical, phobic and depressive reaction patterns that developed concurrently and that represented the patient's manifold initial evasions of her incestuous and other conflicts. One other point deserves emphasis: The very frankness of the patient's "insights" during her hospitalization was of adverse prognostic import, since it indicated a

serious loss of repression, of integrative capacity and of contact with personal and social realities. The primary purpose of therapy, therefore, was to build up adaptations to reality by every means of transference and social guidance that could be mustered, and this therapy was for a limited time partially successful. Unfortunately, the opposite pseudo-“analytic” course was taken by an unqualified practitioner, with the result noted.

### Fugue States

One aspect of the case just described raises the clinical problem of fugue reactions. These states are characterised by periods of automatic activity lasting from a few minutes to several years, during which the patient may be purportedly amnesic for his previous identity and experiences, partially disoriented and unaware of the nature of his acts.\* Such states are therefore of forensic importance, especially since they are directly relevant to the so-called M’Naghten rule which still, despite the combined efforts of the American Psychiatric Association and many legal authorities, furnishes a precedent in English law for judicial procedure in most of our states. The rule derives its name from a paranoid Scotsman who, in 1843, attempted to shoot Prime Minister Robert Peel but killed the latter’s secretary instead. After M’Naghten was acquitted on the grounds of “unsoundness of mind,” the House of Lords canvassed the leading jurists and medical specialists of Britain and formulated the Rule that “every man is presumed sane and to possess a sufficient degree of reason to be responsible for his crimes—except when it can be proved that *at the time of his crime* he did not know the nature of quality of the act he was doing; or, if he did know it, that he was not aware he was doing wrong.”

Fugue states are claimed to occur during the “intoxication” of erotic passions (*crime passionelle*) or at the height of rage or blind panic. However, in criminal cases involving such states, whatever the psychiatric testimony, “justice” is apt to be determined more directly by the respective eloquence and legal dexterity of the opposing attorneys *versus* the current status of public sympathy, indifference or indignation.

On neurophysiologic grounds fugue states of considerable duration may indeed follow severe epileptic seizures, and then be characterized by behavior directly expressive of ordinarily inhibited drives. Since, under such circumstances, the subject’s actions may have criminal implications, his

\* *Casca*: He [Caesar] fell down in the market-place, and foamed at the mouth, and was speechless.

*Brutus*: 'Tis very like: he hath the falling sickness.

*Casca*: . . . When he came to himself again, he said, If he had done or said anything amiss, he desired their worships to think it was his infirmity.—Shakespeare: *Julius Caesar*.  
Act I; Sc. 2.

claims of clouded consciousness or "irresistible impulses" give rise to difficult problems. As we have seen, terming his actions under such circumstances "automatism" clarifies the issue only to the extent that the behavior is thus regarded as released from fully conscious control, possibly as a result of cortical dysfunctions, demonstrable by electroencephalography, similar to those in delerium (Engel, 1950). In view of this it becomes a socio-philosophic and cultural-criminologic rather than a medical question as to just where in the continuum of the progressive disorganization of behavior "intent and personal responsibility" cease. From a purely psychiatric standpoint, the situation is even more complicated by the difficulty of delimiting exactly the factors of "physiologic" release and "conscious" or "unconscious" components (each of them in itself dynamically complex and indeterminate in range) that influence any particular pattern of behavior. A case in point is the following:

CASE 41. *Psychophysiologic nervous system reaction; fugue states complicating epilepsy (DSM II 309.4).* An 8-year-old boy of good intelligence suffered a severe brain concussion which caused a gradually lightening stupor for 24 hours, and headaches, slight vertigo, mild diplopia and transient amnesia for several days. All symptoms then cleared, except for slightly increased touchiness and instability of temper. Two years later, however, while playing a strenuous game of football, he suddenly stopped in the middle of the field, removed his trousers, began to defecate in public and fought furiously when attempts were made to restrain him. Later he walked off the field and came home, where he "awoke" without any memory of the preceding two hours. Several days after this, during a recitation at school, rendered difficult by the *sotto voce* jeers of his classmates, his first major epileptic attack occurred, beginning with a "feeling like I was taller than three people"—an aura that lasted several seconds before unconsciousness set in. Witnesses then described tonic spasms for about 6 seconds, followed by clonic movements, tongue-biting, urinary incontinence and stertorous breathing for 30 seconds or so, then a period of stuporous resistance and blind struggling, from which the patient "awoke" some 15 minutes later confused and exhausted.

The seizure was correctly diagnosed as epilepsy and the patient was placed on phenobarbital medication. However, the attacks recurred at weekly intervals, and remained fixed in pattern, with the addition that the patient almost invariably called out the name of his dead mother just before losing consciousness.

After several months nonconvulsive disturbances of behavior again began to appear, in most of which the patient would become quarrelsome or even violently abusive and aggressive for several minutes, then claim either complete amnesia or only a hazy memory for the occurrence. About a year later the first prolonged fugue occurred: the patient while wandering through a department store in the pre-Christmas season, began to pick up articles of clothing off the various counters with such apparent assurance and nonchalance that the busy clerks thought he was an employee and did not challenge him. However, when he proceeded to walk out of

the store with his unwrapped booty he was arrested and brought to the manager's office. Here he "awoke," and again denied any memory of his actions. The manager, fortunately, considered the boy's claims substantiated by the bizarre technique of his shoplifting, dropped the charges and sent the boy home. Subsequent fugue states involved disoriented wanderings, from which the boy would wake miles from home, violent outbreaks of temper, vague erotic advances to his stepmother and, on some occasions, aimless though public exhibitionism, sometimes leading to arrests. On the last occasion the boy was discharged from police custody only on condition that he receive psychiatric care, and for this reason was brought to the University Hospital.

*Physical findings* were normal except for scars on the tongue, apparently from bites near its margins. Neurologic examinations showed only generally hyperactive reflexes and a suggestive Hoffmann sign on the left. The blood, urine and cerebro-spinal fluid were likewise normal to diagnostic tests. Electro-encephalography showed bursts of 2-per-second waves, and a recording taken during an epileptic seizure showed slow waves with characteristic spike discharges. Air encephalography indicated some enlargement of the ventricles and of the right parietal subarachnoid spaces over possible cortical atrophy.

*Psychiatric Examination.* The patient was an intelligent (I.Q. 127), well mannered, likeable youngster, cooperative and anxious to please. He readily gave a psychiatric history which suggested some of the motivations of his disinhibited behavior during fugue states. The pertinent facts may be summarized as follows: His mother had died when the boy was 8, and his father within a few months married a 20-year-old divorcee who already had a daughter by a previous marriage. The stepmother thereafter ruled the household, with her daughter very much the favorite; in fact, the patient was forced to comply with his stepsister's whims and bear her covert but effective persecution. Moreover, the patient had been required to deliver papers after school to earn money for his own clothes and school expenses. Deprived of his father's sympathy, he had taken to idealizing the memory of his own mother and often fancied himself again secure with her. After the onset of his epileptic seizures he had, in addition, been inconsiderately, even cruelly treated by some of his teachers and schoolmates, though he at first claimed never to have "fought back except, people tell me, when I have my spells." In line with the retrospective glorification of his mother, the patient remembered seeing a movie in which the heroine resembled pictures of his mother. During a love scene he entered into a pleasurable trance, from which he "awoke" after the scene was over, stayed to see the movie again, and had a second "forgetting spell" at exactly the same point in its showing. Similarly, the patient recollected that preceding the "kleptomanic" episode in the department store he had wished pathetically for the clothes he was later arrested for taking. Finally, the guilty erotic coloring of some of his fugue activities seemed to have been precipitated by more or less deliberate attempts at seduction on the part of his young stepmother, when she herself was tempted on occasion by the patient's growing good looks and penchant for either forgetting what might occur or misrepresenting it so that he would not be believed.

*Course and Therapy.* During his hospital stay the patient suffered two typical grand mal seizures with incontinence, deep stupor and electro-encephalographic

changes typical of psychomotor epileptic states, i.e., high frequency, high voltage left temporal dysrhythmias. On one occasion, a fugue state was also observed; the patient, while talking with an intern, suddenly stared fixedly at the door, uttered the name of his mother, walked into the room of an elderly woman patient and, though fully clothed, attempted to get in bed with her. When prevented from doing so, however, he was easily led back to his room, where, without a word of explanation, he went to sleep. An hour later he woke and denied any memory of his actions. Nevertheless, when the topic was approached more gently and indirectly in a subsequent interview, the patient remembered that while he was being questioned about his early life by the intern he had experienced a sudden compelling desire to "find mother," and had gone in a dream-like fashion to the next room, where he half-hoped and half-thought his mother would be. Finally, in this same interview the patient, under sympathetic urging, vaguely remembered some of the details of other fugue sequences, which suggested that the amnesia for these scenes was less a function of loss of consciousness during their occurrence than an almost complete repression of the symbolically aggressive or incestuous nature of his conduct.

*Course.* The patient's grand mal attacks were greatly diminished in severity and frequency over a period of two months by adequate phenobarbital (0.03 gm three times a day) and Dilantin (0.03 gm daily) medication, supplemented by a low fluid, low carbohydrate diet. In addition, arrangements were worked out for the patient to live with an uncle in a Chicago suburb, where he would earn his way and apply his considerable mechanical talents by helping in the uncle's radio shop. The boy improved rapidly in his new environment. His fugue states were reduced to momentary absences with almost no automatisms or residua, and he became much more cheerful, energetic and socially adaptable.

A follow-up three years later showed that, despite his medication, he had continued to have a grand mal attack every four to thirteen weeks, but this had not prevented him from completing an extension course in electronics and joining his uncle as a partner in his business. He reported himself "about as happy as I suppose a guy with fits that nobody can really stop can be. But life isn't so tough as it used to be, and I really think I can get along now."

*Comment.* As can be seen, this patient escaped serious difficulties with the police over thievery and indecent exposure only by relatively good fortune; obviously also, if he had been tried for these offenses, it would have been difficult to defend his actions on the plea that they were uncontrollable "epileptic equivalents" rather than episodes of hysterical behavior, toward which the law would show considerably less tolerance. Nor could absolute differentiations be made on the basis of his later behavior, since, in all probability, antiepileptic medication and psychiatric therapy contributed indistinguishably to his improvement in both respects.

The case illustrates several points, among them: the inadequacy of oversimplified nosologic systems, the multiplicity of factors—physiologic and adaptive—that enter into any single pattern, the indications for and the al-electric, medical, psychiatric and social therapy and, incidentally, the al-

most insuperable difficulties that face forensic psychiatry in attempting to reconcile the complex biodynamic determinants of behavior with a primitive system of legal judgment.

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## Chapter 8

### PSYCHOTIC DISORDERS (DSM II 290-299)

#### DEFINITIONS

In the first edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM I), psychotic disorders were defined as "characterized by a varying degree of personality disintegration and failure to test and evaluate correctly external reality in various spheres . . . individuals with such disorders fail in their ability to relate themselves effectively to other people or to their work." DSM II then added to our nosologic perplexity by stating, "To reduce confusion [sic], when . . . a psychosis is diagnosed in a patient who is not psychotic, the qualifying phrase *not psychotic* should be . . . coded .x6 with a fifth digit." Obviously it becomes necessary to dispel some of the circularity and consequent ambiguity of such "definitions" by parsing their principal terms as follows:

"Personality" is obviously a highly generalized expression with connotations ranging from the exterior and deceptive facade one wears for social purposes (Latin, *persona* = a mask) to the configurations of basic patterns of talents, motivations and adaptations that "integrate" one's unique character (Allport). These concepts, however, must be further modified in accordance with the fact that the "patterns" of personality are continuously changing with growth and new experience, that they never become sufficiently "integrated" (a term borrowed from mathematics, to which it should long ago have been returned) to permit specific psychologic designations, and that in any case no two observers at any given moment ever evaluate another's "personality" in quite the same way or at different moments. Corollary to this is the consideration that even if the observers seem to approach verbal agreement, the terms used in their conjoint descriptions of any "personality" (e.g., arrogant, introspective, dependent, obsessional, psychopathic) retain a wide range of meanings, values and contingencies for those who use, read or hear them. Through such semantic vicissitudes, the term "personality" eventually becomes somewhat less specific than "entelechy," "spirit," "soul" or similar archaic abstractions designed to obscure voids of knowledge and thought.

*"External reality,"* of course, presents another problem of definition that has preoccupied scientists, philosophers and theologians for centuries and can hardly be solved by a casual clause in a diagnostic manual. It remains impossible to answer the disconcerting question as to exactly when poetic dreams or inspiring visions become reprehensible hallucinations, or when irrational but comforting faiths and beliefs necessary to friendly living become socially disturbing delusions that may lead to social conflicts and disruptions.

*Interpersonal relationship* is another key concept in the definition, but one which begs the all-important issue as to who shall judge whatever absolute values are to be attached to social roles and to personal creativities. When Peter the Hermit preached the First Crusade, was he a divinely inspired prophet sent to redeem the sacred shrines of Christendom (as was believed by a continent of "perfectly sane" Christians), or was he a deluded and demon-ridden fanatic who instigated the slaughter of whole populations of innocent victims—as was firmly held by millions of "perfectly sane" Moslems? Did Gaugin, after he deserted his family and social responsibilities, become a parasitic sociopath, or did he escape such condemnation by being a master of painted color and form? Was William Blake, with his ecstasies and visions, a genius or a madman? Were Alexander, Tamerlane, Napoleon and Hitler patriotically dedicated supermen or apocalyptic megalomaniacs? Replies to such questions, obviously, will depend on the personal interests and derived preferences of the observer and on the time and circumstances in which he renders judgment.

Once again, then, "psychoneuroses," "personality disorders" and "psychoses" are neither diseases nor psychiatric entities. Such terms merely connote patterns of individual conduct unsuitable to the milieu, but how long and how seriously deviant depends in large part on contingent and variable historical and social factors. True, "mental retardation" (DSM II 310-315) and intercurrent disease of the brain (290-294) or other parts of the body may further impair a person's ability to perceive, interpret and manipulate his surroundings, but these and the remaining categories of "acute or chronic brain syndromes" and "autonomic and visceral disorders" as listed in official classifications are no more specific as to the actual dysfunctions they produce than the more general categories of "neuroses" (DSM II 300), "personality disorders" (301-304) or "psychoses" (290-299).

### **Need for Nosology**

Should, then, all attempt at the delimitation and classification of behavior disorders be abandoned? The question is a vexatious one, inasmuch

as man has always tried to soften the impact of his complex and onrushing universe by channeling it through filing systems of his own devising, especially with regard to his own behavior. Simple, all-embracing classifications, however meretricious, have therefore always been popular in and out of scientific circles, and will probably continue so to be. A brief historical review will illustrate the point.

Plato considered all deviations in behavior ascribable either to *imbecility* or to *madness*. The latter was caused by an excessive pursuit of pain or pleasure on the part of illbred persons, from which it followed that the ideal Republic should regulate breeding in every sense of the word.

Hippocrates taught that, depending on the balance of their internal "humors," people were *melancholic*, *choleric*, *phlegmatic* or *sanguine* in various degrees—characterizations in common use today. Aretaeus, some sixteen centuries before Kraepelin, described cyclic *mania* and *hypothymia*, as well as several other forms of un-health, or *insanity*. Wilks, in 1674, put it more simply: *stupidity* and *morosity* were the only forms of disorder that need be distinguished.

Then complications began. William Cullen, in the eighteenth century, used the term *neurosis* to represent the functional expression of organic neural disease, whereas Feuchtersleben, in 1845, regarded this disease itself as the *neurosis*, and its behavioral manifestations as a *psychosis*. Pinel differentiated *degenerative* (generally, organic) from *nondegenerative* (idiopathic) disorders, whereas Kahlbaum, in 1863, erected a much more elaborate nosology as follows: (1) the *vesanias* (literally wrong health), causing *melancholy*, *mania*, *confusion* or *dementia*, (2) the *recordias* (wrongheartedness), (3) the *dysphrenias* (toxic states) and (4) the *paraphrenias*, subdivided by age groups into *neophrenia*, *hebephrenia* and *presbyophrenia*. Falret, in 1851, had described a *folie circulaire*, and this recurrent concept became stereotyped when, in 1896, Emil Kraepelin formulated the category of *manic-depressive psychoses*, in which the *manic* phase, characterized by euphoria, flight of ideas and pressure of activity, alternates with the *depressive* phase, marked by melancholic moods and sluggishness of thought and action. Kraepelin likewise proposed two other major categories of psychoses, comprised of (a) the *paranoias*, distinguished by elaborately organized systems of delusions, and (b) *dementia praecox*, which he considered to be an organic disease of puberty with *simple* (insidious), *hebephrenic* (rapidly disorganizing), *cataxic* (passive, cataleptic or excited) and *paranoid* forms, all leading inevitably to physical and mental "deterioration." In 1911, Eugen Bleuler, under the influence of Freud and Jung, modified Kraepelin's concepts by proposing that all types of *dementia praecox* were characterized by a discrepancy or splitting (*schizophrenia*) between the "emotional" and the "intellectual" aspects of

the "psyche," giving rise to the coexistence of ideas not apparently related to their concurrent motivations or affect. Accompanying such schisms were solipsistic symbolisms and unique forms or blockings of communication. These were to be distinguished from *secondary symptoms*, such as *autism*, *motor stereotypies* (including catatonia), vivid and fantastic hallucinations and "impenetrable" delusions.

Kraepelin's nosology, filled out somewhat by Bleuler's clinical descriptions and dynamic insights, satisfied the needs of many psychiatrists for an ostensibly authoritative code of diagnostic reference, and was therefore officially adopted for "statistical use" almost everywhere. For this reason, few clinicians trained outside the Johns Hopkins school of *psychobiology* paid much heed to Adolf Meyer's quiet but insistent pleas that psychiatrists, unlike other specialists, dealt primarily not with specific deficiencies, cripplings or afflictions, but with the *various combinations of effective and ineffective ways in which patients spent their energies*. Meyer proposed that all disorders of behavior be regarded as deviant forms of *ergasia* (Greek *ergon* = energy, work), with major logical subdivisions. Among these were: the *oligergasias* (*oligos* = few), denoting subnormal capacities, as in mental deficiency; the *kakergasias* (*kakos* = bad) or errant efforts, as in the neuroses; the *thymergasias* or disturbances of mood; the *dysergasias* or toxic psychoses; and the *parergasias* (*para* = beside), indicating partial dissociation of thoughts and actions. In the Meyerian system, all such terms were supplementary rather than exclusive designations for the protean varieties and combinations of "normal," "neurotic," "sociopathic" and "psychotic" behavior. Almost concurrently, Freud attributed the "actual neuroses" to sexual exhaustion and labeled the schizophrenias the *narcissistic neuroses*, incidentally inferring that the latter were not amenable to analytic therapy.

However, the Kraepelinian system continued to be used in almost its original form (cf. the 1942 edition of the Standard Nomenclature of Diseases) until World War II, when its diagnostic inadequacies and misleading prognostic implications led to serious errors and confusions in the all-important field of military psychiatry. In order to correct this situation, William Menninger and his staff at the Army Surgeon General's office issued a Technical Medical Bulletin (no. 203, Oct. 19th, 1945) in which a simpler and more workable system was made official. Only five major categories were recognized:

- (1) *Transient personality reactions to acute or special stress*;
- (2) *psychoneurotic disorders* such as *dissociative* (fugue), *phobic*, *conversion* (hysteric) and *somatization* (psychosomatic) reactions;
- (3) *character and behavior disorders*, such as pathologic personality types, alcoholism or drug addiction, and various *immaturity traits*;

- (4) *disorders of intelligence*, either genetic or acquired; and
- (5) *psychotic disorders*, subdivided into schizophrenic, paranoiac, affective (including involutional melancholia) and organic.

Further, the Bulletin provided: (1) That *any combination of primary disorders and secondary reactions and subreactions* could be listed in their order of importance as they occurred together in any patient, and (2) that in each case entries were also to be made as to (a) the *type and severity of the symptoms*, (b) the *external precipitating stresses* which sparked the clinical reactions, (c) data as to the patient's *predisposition* to the disorder, and, finally, (d) the *degree* of resulting *incapacity*, graded as none, minimal, moderate or marked. This more comprehensive approach to the vagaries of human behavior under military stress was also adopted by the Navy and soon proved to be so useful in combined applications to military and civilian psychiatry that for a time it likewise became standard practice in the Veterans Administration. Further emendations and additions were incorporated into the 1952 Revision which, for example, listed various "schizophrenic reactions" but eliminated schizophrenia itself as a definitive psychosis.

Many psychiatrists, however, continued to object to this; for example, Lauretta Bender and others insisted that "true schizophrenia [is a] specific disease entity, that it is a specific encephalopathy recognizable before the age of eleven," and that the disease "can be diagnosed with precision by pathognomonic alterations in muscle tone, sleep rhythm and motor control and by disturbances in self-orientation or body image." As to psychogenic factors, Bender maintained that because of such deficiencies and lack of response to maternal care, schizophrenic children tend to be overtly or covertly rejected by their mothers at a time when they are abnormally vulnerable to such deprivation. As a result, they react immediately by regression or withdrawal (*autism*), or with an interim stage of restless inquisitiveness, activity (the "overactive" child) or false precocity which also soon breaks down into frankly psychotic behavior. Bender's concepts, which were in part shared by Kanner, Spitz, Tietz and other child psychiatrists, once again assigned to genetic factors the primary role in the etiology of schizophrenia, although its symptomatic expressions were admittedly modifiable by circumstances and experience.

Gabriel Langfeldt of Oslo, whose views generally reflected western European psychiatry, likewise believed that *process schizophrenia* is a disease entity characterized by (1) adverse heredity, (2) *lysosomal* (poorly integrated) or *ectomorphic* (hypersensitive) constitution, (3) a "schizoid temperament," (4) absence of psychogenic factors, and (5) "endogenic" symptoms such as "massive dereism," depersonalization and "inexplicable" delusions which lead to inevitable "deterioration" in about 90 per

cent of cases despite all known treatment. Meduna distinguished from such cases a large group of "pseudo forms" or *oneiroprenias* (from Gk. *oneiros* = dream) attributable to unknown endocrine or metabolic disturbances which, he thought, were amenable in about 60 per cent of cases to electroshock therapy. Lothar Kalinowsky and Paul Hoch separated from this general rubric another entity they call *pseudoneurotic schizophrenia*, distinguishable (a) by severe and persistent neurotic symptoms which may temporarily mask pervasive, deep and easily elicited *pan-anxiety*, and (b) by a protean variability in behavior that may range from mild but fantastic idiosyncracies to bizarre acts such as the symbolic but deliberate gouging out of one's own eyes or the self-amputation of breasts or genitals. Fortunately, before their manifestation in such overt behavior the underlying psychotic tendencies may often be revealed by close clinical observation or by Amytal hypnosis. Electroshock and probing analytic therapy were to be avoided in such patients, whose only hope lay in lobotomy or topectomy, followed by realistic, explicit and skillful guidance toward occupational and social readjustments well within their diminished capacities.

Diametrically opposed to these views are those of equally competent clinicians such as Bowman and Rose, Menninger, Rado, and more recently, Mosher and others who favor an almost complete break with Kraepelin. Such men not only advocate a dissolution of the traditional boundary lines between the various psychoses, but also question the validity of the supposed distinctions among the so-called neuroses, sociopathies and psychoses, as outlined below.

### Protean Nature of the Psychoses

In view of the disparities of opinion as to the heuristic value of current diagnostic categories, it seems best at present to avoid assertions as to whether or not there are various clinical entities sufficiently related to be grouped under the rubric *psychoses*. Instead, we need only cull out, insofar as possible, those patterns of behavior which, when manifested by a patient with sufficient consistency over a long enough period of time, render him currently liable to be diagnosed psychotic by most psychiatrists in his immediate milieu. This approach is admittedly relativistic; however, if it is regarded as too vague, then the physician who thus rejects it must be prepared to specify the level (not range) of blood pressure at which a patient may be diagnosed as "hypertensive," the exact number of milligrams of dextrose per liter of blood over a stated period of time that differentiates "normal" or episodic hyperglycemia from "diabetes," the precise length of a post-traumatic hairline fissure in a bone to constitute a "fracture," or how many alveoli must be filled to what degree before a "bronchitis" be-

comes a "bronchopneumonia" or "pneumonia." To take the last example, when a sufficient number of factors is present to a sufficient *degree* in a predesignated *configuration* (for example of fever *frequently* over 100°, *enough* change in the sedimentation rate of the *number* of leukocytes, "definite" to "extreme" pulmonary mottling or consolidation as revealed acoustically or on x-ray examination), the diagnosis of "pneumonia" becomes "manifest"—but that does not alter the fact that every code-determinant may be present in every degree of morbidity and in almost every conceivable combination with every other in a range from mild "coryza" to terminal "pneumonitis." So also in the much more complex fields of total human behavior, it is best, in accord with modern configurational dynamic orientation, to dispense with monothetic, all-or-none concepts and instead qualify every clinical diagnosis with special etiologic, developmental, symptomatic, comparative and prognostic contingencies.

An immediate point to this statement is perhaps best furnished by the diagnosis of "three-day schizophrenia," familiar to military psychiatrists. In Kraepelin's system this designation would have been regarded as a nosologic absurdity, and yet the term was used frequently and meaningfully in World War II to describe a state of bizarrely hallucinated automatism or pseudo-affective excitement which occurred in "previously normal" servicemen subjected to extreme physical or military stress. Under such circumstances, the reactions were often clinically indistinguishable from classic "catatonic stupors" or "furors" except that with minimal care the patient recovered in two or three days and could then in most cases return to duty—an eventuality completely at odds with traditional predictions. The argument was, of course, raised in some quarters that these cases were thereby "proved not to have been true schizophrenia," but such *post hoc* reversals of judgment could easily have been avoided by broadening the initial meaning of the term, divesting it of fixed prognostic implications, and then studying in objective detail the primary dynamic factors which influenced the etiology, therapy and outcome of the individual case.

#### Criteria of Psychotic Reactions

At present, therefore, the term "psychotic" may be applied to a patient when his behavior is characterized by *one or more* of the following deviations:

First, *marked and continuous deviations of affect*. Various concepts of "emotion," "affect," and "feeling," have been discussed previously in Chapter 5; here we may consider the terms to connote the degrees of *participation in and reactions to the physical and social milieu*. Thus, in the *affective disorders*, unjustified but persistent euphoria is the main feature of

that rare disturbance called *mania*, contrasted with fixed hypothymia in various forms of *depression*. So also, impulsive volatility constitutes a prominent feature of the *sociopathic psychoses*; whereas absent, shallow or grotesque feeling tones (i.e., those that do not correspond to or are "split off from" their accompanying ideation) are regarded as *schizophrenic*. It may be noted, however, that none of these deviations of affect implies absence of *awareness* or an otherwise impaired sensorium; on the contrary, a patient may emerge from months of an apparently frenzied mania or an ostensibly insensate "catatonic stupor" with remarkably clear perceptions and memories of all that had happened to him while he was either behaving with reckless abandon or seemed inert, remote and unresponsive.

Second, psychoses are characterized by *marked aberrations from the accepted interpretations of and reactions to "reality" as currently defined and delimited by the social and cultural milieu*. In effect, the behavior permitted will vary widely with time, place and social contingency, but operational boundaries are set for "normal" which cannot be transcended. For instance, it is admissible to "see or feel the Presence," "speak with tongues" and go into convulsive movements or ecstatic trances (Greek *ekstasis* = religious possession) during a Holy Roller revival; however, should the person so visited by "a spirit" experience and report the same hallucinations, shout the same neologisms or manifest the same cataleptic motor behavior at his work or on the street, he might be subject to legal commitment as an acutely disturbed schizophrenic. Such parameters likewise vary with time, place and culture in regard to tolerance of aggressivity, the intensity and form of sexual expression in various cultural settings (e.g., Suono Indians copulate openly, but do not eat in public), the latitudes of acceptable logic (e.g., "Communists . . . Democrats . . . Republicans . . . Jews . . . Negroes . . . the Devil . . . cause all our troubles"—or—"the only way to deal with Russians is to hydrogen-bomb them out of existence") or other political and social prejudices. Even then, it is only when "thinking disorders" are manifested in behavior that is flagrantly and continuously carried beyond what is generally allowed with respect to time, place and concurrently accepted interpersonal and cultural context that they are labeled psychotic.

Third, and closely allied to the second criterion, psychoses are characterized by *serious impairment or disorganization of behavior and persistent reversion to fragmented or pseudo-infantile patterns of conduct*. A dependent adult who catches a cold may be permitted by his indulgent family to lie a week in bed, to have his meals and even his wash water brought to him, and to receive other services not actually justified by his relatively minor disabilities. However, if he regresses beyond certain limits and keeps exaggerating or perverting "normal" idiosyncrasies of appeal or

dependence, then even the most permissive family will eventually begin wondering if his "mind has become a little affected." Should these aberrations become extreme (e.g., the patient demands to be spoon-fed, requires a pacifier to keep him from sucking his thumb or finally needs diapering to counteract excretory carelessness) and persist to the eventual exhaustion of the family's patience, a psychiatric consultant might diagnose hebephrenic schizophrenia and recommend commitment.

Finally, psychoses are also diagnosed when there is *organic impairment of cerebral function of sufficient degree to endanger the survival of the patient*. This may be acute to (a) acute toxic or metabolic disturbances giving rise to *deliriums* characterized by disorientation, confusion and fleeting but vivid hallucinations (as in delirium tremens or toxic-infectious psychoses), (b) cortical dysrhythmias (*epilepsies*), or (c) permanent disorders of brain function caused by injuries, infections, tumors, circulatory deficiencies or senile cerebral changes which result in demonstrable impairments of perception, integration, memory (especially recent recall) and of the speed, versatility and effectiveness of total adaptive response. The person so affected (for example, a general paretic) will endeavor to compensate for his internally sensed deficiencies by reactive aggressions, fanatic religiosity, or other labile compensations still within his capacities. However, these are secondary neurotic or psychotic reactions only indirectly attributable to the organic pathologic process per se, and are to be distinguished from it with respect to diagnosis, prognosis and therapy.

### Clinical Significance

The preceding discussion indicates the wide variety of current connotations of the deceptively terse term *psychosis*. Yet, despite the generality of this approach, the concept attains an aspect of unity from the clinical consequences of such characteristics. Some of these consequences may be listed as follows:

*Dereism.* Since the patient perceives and interprets reality in ways that differ widely from those accepted by most of his fellows, the therapist is faced with the necessity of learning to see the universe anew as each of his psychotic patients sees it (R. Laing, D. Cooper),\* else he may blunder badly in attempting to communicate and interact with the patient. This problem is further complicated by the serious difficulties which arise when the same words have implosively different meanings to patient and therapist, when the logical systems of the two are initially almost incompatible, and when interests and goals are at first widely disparate.

\* There is a pleasure, sure, in being mad Which none but madmen know!—Dryden, *The Spanish Friar*.

*Difficulties of prediction and control.* The term "implosive" as used above may become explosive insofar as the behavior of a psychotic, precisely because of his uniqueness and remoteness, may become bizarre or dangerous in ways which cannot always be foreseen or forestalled. Nearly every physician has had one or more "unpredictable" suicides among his depressed patients, and not a few psychiatrists, at least once in their experience, have been personally threatened, vilified or physically attacked by a patient whom they have tried to help. Although unprovoked psychotic violence is actually rare, the currently increasing social vulnerability of physicians in general, and psychiatrists in particular, renders this consideration relevant, both for their own protection and that of society.

*Medical considerations.* The physical health of the psychotic also requires particular attention since, in contrast to somatic disturbances in the neuroses, the psychotic patient is (a) less acutely aware of intercurrent bodily dysfunctions, (b) less accurate in describing them and (c) less capable of cooperating in their treatment. For such reasons continuous extramural observation or legal commitment as somewhat differently prescribed by the individual states in the Union is often advisable.

*Interpersonal isolation.* As already indicated, this occurs because the patient, continuously suspicious of his universe and the people in it, erects defenses that often defy frontal penetration. The barriers may be those of arrogant and reckless self-assertion as in mania, or fixed anaclitic dependency as in depression, or spreading distrust and hostile grandiosity as in paranoia, or affective obtuseness and narcissistic withdrawal as in schizophrenia. Whatever their form, such attitudes vitiate, limit and pervert the interpersonal relationships on which a therapeutic rapprochement must be based.

### Forms of Psychoses

*Psychoses due to impairment of brain tissue function.* In DSM I, with many subheads in DSM II, 290, these psychoses are described as essentially characterized by (a) defects in *orientation* and in *memory* (sensorium), (b) disorganization of *intellectual functions* such as perception, association, integration, abstraction and symbolization, and (c) consequent *impairment of judgment* as measured by lack of versatility and effectiveness in action. In this connection, recent studies by MacLean, Pribram, Fulton, Bard, Heath, the author and others indicate that lesions in the cerebral paleococortex (the orbital gyri, the anterior insula and hippocampus, the pyriform and limbic lobes or the septum pellucidum) and in the thalamus and amygdalae may also greatly influence the form and intensity of affective expression by altering the functions of the "visceral brain,"

comprised mainly of these areas and their interconnections with the hypothalamus. There may also be more specific localizations within this neural complex, inasmuch as experimental destruction limited to the amygdalae and underlying orbital cortex in higher animals diminishes aggressive behavior and releases exploratory activity undeterred even by adverse experience (Kluver and Bucy; Masserman and Pechtel), whereas lesions in the dorsomedial thalamus decontrol erotic and aggressive reactions (Bard and Mountcastle; Rioch, et al.), especially when these had previously been rendered conflictual and excessively repressed (Masserman and Pechtel). Such findings have led Mettler, Cairns, Dax and Radley-Smith, Scoville and other neurosurgeons to perform specific operations, such as removing Brodman areas 9, 10 and 46, to disorganize obsessive-compulsive ruminations, undercutting the orbital gyri for depression and torpor or electrocoagulating the anterior nuclei of the thalamus and thus disrupting their connections to the cingulum (areas 23 and 24) for schizophrenic regressions (Spiegel and Wycis).

Whether or not further laboratory research and clinical experience will confirm these or other neuropsychiatric relationships, there is little doubt that the reliability of man's behavior (i.e., its order of suitability, versatility and effectiveness) and its affective coloring (control, intensity and somatic accompaniments) are directly dependent on the integrity and proper functioning of his central nervous system, especially its cephalic portions. Neural deficiencies render the organism more liable to adverse experiences, and these in turn impair internal neural functions, thus closing a vicious cycle of defect, failure, a lower level of compensation, increased internal defect, greater failure and a still lower level of compensation until a nadir is reached. Impaired brain tissue function, especially when it has progressed to the point of manifest handicap, is therefore nearly always complicated by an admixture of neurotic and psychotic reactions.

*Acute brain disorders.* These were defined in DSM I as "the result of temporary, reversible, diffuse impairment of brain tissue function [which] may release . . . hallucinations, poorly organized, transient delusions and behavior disturbances of varying degree; in DSM II (293-294) they are further subdivided as to traumata, infections, toxins, etc. (codes 290, 291). The term "reversible" may be misleading since, in the case of alcohol (Bender and Schilder) and probably with other drugs, the intoxicant produces additive tissue injuries which are, therefore, not "temporary." This applies even more directly to concussions, convulsive electrical stimulations, infections and other acute anoxic or circulatory disturbances, each of which may take a small toll scarcely detectable in most cases by ordinary means from among the ten billion cells present originally. Nevertheless, this is an irreplaceable loss and occasionally a tragic one that

may reduce a genius to an ordinary mortal or the latter to a marginally defective one.

In addition to the etiologic factors listed above, the current classification lists acute syndromes with convulsive disorders, metabolic disturbances, intracranial neoplasms and general or local disease of unknown cause.

*Chronic brain disorders* (DSM II 291, 292). These are expressed as residual impairments of cerebral function when the pathologic processes listed under acute brain syndromes leave permanent organic scars in the cerebral tissue. Here also the defects may be accompanied by neurotic or psychotic disturbances in behavior, or contribute to the formation of these aberrations as reactive and compensatory phenomena. Moreover, if the organic destruction is extensive, dementia may result, as after cerebral syphilis, traumatic electroshock or other prolonged or repeated insults to cerebral tissue. The injuries officially classified are: *congenital or neonatal defects; meningoencephalitic, vascular or other forms of syphilis; bacterial or other infections; chronic intoxications; trauma; arteriosclerotic, embolic or hemorrhagic vascular lesions; convulsive disorders, senility, nutritional and metabolic disorders*, including Alzheimer's progressive brain atrophy; *neoplastic changes; diseases of uncertain cause*, such multiple sclerosis or Huntington's chorea; and finally, those of completely unknown etiology. The "*involutional psychoses*" of the presenile period are identified by "*prolonged . . . worry, intractable insomnia, guilt, anxiety, agitation, delusional ideas . . . depression . . . or paranoid ideas*". However, the latter psychoses are not classified in the organic syndromes, but are placed among the *disorders of psychogenic origin*.

*Affective reactions.* According to the accepted definition, these are characterized by a "primary, severe disorder of mood, with resultant disturbances of thought and behavior in consonance with the affect." Two forms are distinguished:

*Manic-depressive reactions (or psychoses)* with *manic* overtalkativeness, flight of ideas and increased motor activity, alternating with *depression* (mental and motor retardation and inhibition . . . uneasiness and apprehension) or presenting *mixed forms*.

*Psychotic depressive reactions* are differentiated from the above by the more frequent occurrence of hallucinations and delusions, the absence of marked manic swings and a more evident relationship to environmental precipitating factors (*reactive depressions*).

As may be inferred from these descriptions, the phrase "disorder of mood" may also have wide connotations and lead to endless but futile discussion not only as to the subclassifications of the so-called affective disorders, but serious question as to the validity of this general category.

Certainly, classic "manic" states, despite current preoccupations with lithium therapy, are relatively rare in objective clinical experience, and the term *manic-depressive psychosis*, despite its frequent use, has little clinical or prognostic specificity. Similarly, *depressive reactions* may spring from any combination of organic and environmental stresses and be combined with any conceivable configuration of other aberrations of behavior, with or without suicidal tendencies. The contention that depressive states are more amenable to various forms of therapy, including electroshock, than are the psychopathies or the schizophrenias is a valid one, but mainly in the sense that depressive reactions are likely to occur only under special and temporary stresses in relatively more stable and adaptable persons, with the result that the reactions of restless agitation and flighty preoccupations (frequently miscalled *mania*) or of melancholic dependence and regression (*depression*) are either spontaneously self-corrective or are more easily treated by a variety of means.

#### **Schizophrenia (DSM II, 295)**

This category comprises a wide range of disturbances in behavior vaguely described in the 1952 manual as "marked by strong tendency to retreat from reality, by emotional disharmony, unpredictable disturbances in stream of thought, regressive behavior, and in some, by a tendency to 'deterioration'." The only terms in this definition that at first sight might distinguish schizophrenic reactions from others are "disharmony," "unpredictable" and "deterioration," but unfortunately the first two are but measures of our present lack of perceptive and prognostic ability, whereas the third occurs physically in the organic psychoses, and in a social sense in all untreated or progressive maladaptations from unadjusted mental retardation to obsessive-compulsive and other forms of neuroses. It is for such reasons that under the rubric of the so-called schizophrenias, absolute distinctions are being slowly relinquished in favor of relative and transitional diagnostic concepts such as those previously outlined in this chapter. Nevertheless, it is still the custom to subdivide the schizophrenic reactions into the following types:

*Simple.* This is applied to patients who manifest gradual withdrawal of social and occupational interests, increasing self-isolation, and eventual reversion to empty day-dreaming, apathy and idleness.

*Hebephrenic.* In this form, various puerile ("silly") mannerisms, peculiar affective distortions and bizarre delusions may appear, giving rise to progressive and finally chaotic disorganization of behavior.

*Catatonic.* Characterized by protracted inhibitions (mutism, stupor), autisms (neologistic speech and solipsistic behavior) or stereotypies

(verbigeration, echolalia, negativism, echopraxia) occasionally interrupted by states of wildly irrational and sometimes destructive excitement; eventually the patient may deteriorate to a state of vegetative otiosity.

*Paranoid.* Marked by delusions of grandeur, persecution, omniscience or omnipotence which ostensibly differ from those of "true paranoia" in that the former are accompanied by hallucinatory experiences and are too unrealistic, bizarre and self-contradictory to form even a pseudological system; ergo, the thought processes of the paranoid schizophrenic eventually disintegrate into unintelligibility. Unfortunately, these traditional distinctions not only occasionally fail to differentiate the two forms of paranoia mentioned, but may not mark a definite border between paranoiacs and persons we call poets, dreamers, crusaders or zealots.

*Schizo-affective.* Used to denote admixtures of schizophrenic and deviously affective behavior—a designation rarely employed but that, operationally speaking, actually applies to all cases.

*Acute undifferentiated.* This syndrome, which may appear suddenly under intense stress or after an insidious build-up of tension, is characterized by intellectual confusion, affective turmoil, fugue-like wanderings or stereotypies, and clinical recovery after a few days or weeks. However, a defensive amnesia for the attack usually persists, and probing as to its causes is resisted. If the stresses continue or recur, subsequent reactions may become more serious and protracted and more deeply disruptive to basic personality patterns.

*Chronic undifferentiated.* This is reserved for those cases (which constitute the majority and possibly all) that do not fit any of the categories already listed.

*Childhood type.* This becomes manifest before puberty and is characterized, according to Bender, not only by pre-schizoid distortions of thought and imagery but also by infantile hyperplasticities, ataxias and other failures in bodily development.

*Residual.* This term is applied to the schizophrenic characteristics which remain after treatment.

The biodynamics of the schizophrenic reactions and their pharmacotherapy will be discussed below and in a subsequent volume in this series.

### **Paranoid States (DSM II, 297)**

These are purportedly characterized by systematized delusions that follow with ostensible logic from absurd premises, but serve to give the patient, even when he believes himself martyred, a sense of mission, importance and power. In the pure case, gross disturbances of mood or schizophrenic sensorial aberrations such as stupors or hallucinations are

absent, so that thought and affect remain relatively compatible. Two forms are distinguished:

*Paranoia* is characterized (DSM I) as "An intricate, complex and slowly developing [delusional] system, often logically elaborated after a false interpretation of an actual occurrence. Frequently, the patient considers himself endowed with superior or unique ability. [There is] relative intactness and preservation of the remainder of the personality, in spite of a chronic and prolonged course."

*Paranoid state.* This designation is applied to patients who seem midway between paranoia and paranoid schizophrenia. Such states may be transient (especially when precipitated by unusual intercurrent physical or social stresses), or they may gradually assume more definite paranoiac or schizophrenic forms.

### Summary of Psychiatric Semeiology

In the "functional psychoses" there occur:

Loss of contact with, or marked distortions of, generally accepted concepts of time, place and person (*sensorial aberrations*) or of causality (*thinking disorders*) which may become manifest as sensory misperceptions (*illusions*), vividly projected imagery (*hallucinations*) and unrealistic convictions (*delusions*).

Overintensity, fixity or inappropriateness of situational or interpersonal responses (*distortions of affect*): e.g., restless hyperactivity with pseudo-euphoric ebullience (*mania*), persistent feelings of hopeless futility (*depression, melancholia*), irrationally systematized and exaggerated reactions of resentment, fear, anger or grandiosity (*paranoia*), emotional blunting (as in *hebephrenia*), or bizarre *dissociations* (*schizophrenia*) between situation and response, sometimes leading to explosive outbursts (*catastonic excitements*).

Excessive and persistent reversion to childhood patterns (*regression*) no longer appropriate to adult life: e.g., pseudo-infantile passivities, destructive aggressions and uninhibited or perverse eroticisms.

*Concurrent personality disintegration*, with release of repetitive, dissociated part-patterns (*echopraxia, stereotypies, autism*).

In the *acute brain disorders* there are severe but reversible derangements of apperceptive, interpretive and manipulative (intellectual) capacities, often with confusion and/or disruptive panic, as in the *toxic deliria*, or finally,

In the *chronic brain disorders* there occurs a permanent impairment (deterioration) or loss (*dementia*) of intellectual capacities as in the various forms of organic cerebral disease.

**Organic Factors**

Freud, despite his preoccupation with the effects of early childhood experiences on all later behavior, remained convinced throughout his life that both the neuroses and psychoses were essentially metabolic (probably hormonal) disorders, and predicted that their ultimate therapy would be specifically pharmacologic.\* Some clinicians today find this to be almost their only point of agreement with Freud, and continue to search for a genetic-somatic cause of the psychoses that would furnish a rational basis for treatment. As noted, no such etiology has as yet been confirmed, but combinations of metabolic, pharmacologic and psychologic stress (biodynamically considered, the three forms merge) can certainly induce "organic" psychosis (*acute and chronic brain disorders*) and markedly influence the so-called functional psychoses (*manic-depressive, schizophrenic and paranoiac reactions*) as follows:

**PHYSIOLOGIC STRESSES**

It has long been known that acute want of oxygen, prolonged hunger or thirst, extremes of temperature, excessive fatigue and other physiologic deprivations or insults can produce serious disturbances of consciousness, thought and action which may assume psychotic proportions. Recent studies on the effects of one such form of stress deserve special consideration:

*Sleep deprivation.* The intense weariness, distress and confusion and the desperate seeking for relief during sleep deprivation—a torture that leaves only internal scars—has made this a favorite form of duress among medieval and modern inquisitors seeking false confessions ("brain washing") and religious or political indoctrination (cf. A. Glass, J. Frank). From the clinical standpoint, L. J. West and others have demonstrated that interference with conditioned sleep cycles (Kleitman) by enforced wakefulness for 72 hours or more causes most subjects to develop marked

\* Freud attributed what were formerly known as "neurasthenic" symptoms to the supposedly debilitating effects of masturbation or *ejaculatio praecox*, and distinguished these *actual neuroses* from (a) the *psychoneuroses*, which were in part experientially as well as organically determined, and (b) the *narcissistic neuroses* (psychoses) unreachable by analysis because of the self-isolation (narcissism) of the patient. In his *Outline of Psychoanalysis* (published posthumously in 1949), he wrote: "The future may teach us how to exercise a direct influence by means of particular chemical substances upon the amounts of energy and their distribution in the apparatus of the mind. . . . But for the moment we have nothing better at our disposal than the technique of psychoanalysis, and for that reason, in spite of limitations, it is not to be despised."

hypersuggestibility, sensorial aberrations, affective or schizoid distortions, and an increased susceptibility to psychotogenic drugs (Bliss et al.). However, the delirious nature of the induced effects and their rapid amelioration after rest and sleep suggest that physiologic stresses, like their pharmacologic counterparts, described below, can induce only the toxic-exhaustive forms of behavior disorder.

### PHARMACOLOGIC INFLUENCES

Since neolithic times, man has apparently known the intoxicant effects of various brews and fermentations (wines and beers in pre-Biblical Egypt and Chaldea) and various plant extracts (opium poppy in the ancient East; cocaine in pre-Columbian South America, peyotl in Aztec Mexico). Indeed, man has always avidly sought such substances to mediate temporary or permanent escape from harsh realities into a haze of forgetfulness, fantasy and disinhibition, during extremes of which his behavior would be termed "psychotic." Recently, however, specific chemical compounds\* have been found which, when administered in amounts as minute as 25 micrograms, can cause states of disorientation, depersonalization, affective distortion and hallucinatory and delusional behavior lasting from several hours to several days. These drugs have been termed *psychotogenic* by those who believe that they produce "model psychoses" and may indicate that all psychoses are of chemical origin. However, the validity of these inferences is thrown into question by many considerations, among them (a) that as many as half of the volunteers presumed to be normal controls for such studies were later found to have been psychiatrically disturbed to begin with (Pollin and Perlin); (b) that almost any substance, including common psychiatric medications such as the amphetamines (Connell), barbiturates (Isbell), isoniazid (Jackson) and various ataractics (Diekel and Dickson) may, when taken in excess, cause "psychotic" reactions; (c) that metabolically harmless *placebos* such as milk sugar, when given under conducive circumstances, can also induce aberrant and bizarre behavior (v. Beecher, Lasagna and S. Wolf, and Gildea's control studies on R. Heath's "taraxein"); and (d) that psychotic patients themselves show no constant differential effects to any known "psychotogenic" drugs, and rapidly develop a tolerance to them.

In view of these and other methodologic considerations it must be inferred that although various substances, some in minute quantities, can

\* E.g., lysergic acid diethylamide (LSD-25) (cf. H. Solomon, Bercel et al.), mescaline (Kluver, Huxley), bufotamine (Fabing), dimethyltryptamine (Evarts) S.T.P., and the atropine-like substances JB-318 and JB 329 (Abood).

cause temporary deliria or perhaps even chronic deteriorative psychoses through toxicosis or cerebral damage, this effect is only ancillary to the etiology, psychopathology or therapy of the psychotic states.

### PSYCHOLOGIC STRESS

*Apperceptive.* Walter and Ulett have shown that "psychic driving" induced by so simple a stimulus as a light flickering at a rate that happens to coincide with and reinforce the electrical beating of the cerebral cortex (8 to 12 per second alpha rhythm) may induce states of tension and disorientation or, in especially sensitive subjects, convulsions followed by aphasia and automatism (fugue states). In a broader application of the disrupting effects of communication overdrive, J. G. Miller has pointed out that modern life is becoming so complex that the items of information which the human brain must receive, interpret, sort, classify and respond to appropriately may have begun to exceed its capacities as either a digital or analogic computer, with resultant "nervous breakdowns" in an almost literal parallelism to those in an overloaded cybernetic (Greek *kybernos* = governor) system. So also, as Masserman and E. Orloff have shown, irregular delays or unpredictable changes in routinely expected feedbacks (Principle of Uncertainty) may disrupt behavior to the point of serious disorientation and irrationality.

*Isolation.* Of equal theoretical and clinical interest is the fact that a marked diminution of contacts with the external environment can also cause serious disorders of function. Jacques Loeb believed that all life avidly seeks for stimulus and reaction (e.g., plant roots "seek" water; flowers, the sun), and called these patterns tropisms. Animals search for progressively greater varieties of experience: a rat will spontaneously run alternative routes through a maze (Heron) and a cat or monkey will prefer exploration to food or sex (Butler). Most humans abhor "boredom," however safe—a circumstance that motivates much travel or research and, conversely, makes solitary confinement, even apart from the factor of social rejection ("being sent to Coventry"), among the most dreaded of punishments for child or adult. Persons too long deprived of living company, even in adventures of their own choosing, experience what Admiral Byrd, during his Antarctic vigil, called a "terror of loneliness"—a state that often necessitates an elaboration of ritual and a vividness of imagery which may reach the intensity of relentless obsessions and wishful hallucinations. Captain Joshua Slocum, thrice incapacitated while sailing single-handed around the world, each time was convinced that he saw and heard a lusty, cheerful bo's'n steer his little yawl *Spray* safely through gales and

dangerous seas while he lay helplessly ill below. So also, John the Baptist, Joan of Arc, Charles Lindbergh and countless other isolates, from deserted children to lost spelunkers, have rejoiced in times of stress in desperately fantasied mortal or spiritual rescuers who were as "real" as man's eternal yearning for succor.

These observations have been experimentally confirmed by the work of Hebb, Lilly, P. Solomon and others, who deprived normal subjects of customary sensory stimuli by suspension in a warm bath, by keeping them in a continuously darkened room, and by earplugs or other modes of masking sounds, and noted that within six hours to three days, many subjects became intensely anxious, showed disorders of perception, memory and self-image and developed somatic disturbances and various hallucinations that persisted for hours or days after release. Any variations in technique that admitted a greater access of diverting stimuli mitigated these effects (Vernon), and the responses were also greatly influenced by the disparate meanings the same situation had for different subjects; nevertheless, sensory deprivations or, more generally, feelings of personal isolation may be exceedingly important factors in a wide range of clinical phenomena. Among these may be cited the accident-causing illusions of a weary truck driver too long on a monotonous run; the "break-off point" at which a pilot of a supersonic plane—suspended seemingly silent, motionless and alone in the endless stratosphere—experiences a panic of "disconnectedness with the world"; the observation that 7 per cent of patients blindfolded and "at complete rest" after cataract operations suffer psychotic episodes (Ziskind); the fact that consigning disturbed alcoholics to a "quiet darkened recovery room" for complete rest favors the onset of delirium tremens (Lemere); or the possibility that persons socially isolated from childhood because of real or fancied disappointments or rejections may develop schizoid disturbances of thought, affect and reality-interpretation.

With these additional data as background, we may proceed to consider the various forms of psychoses under their usual classifications of manic-depressive, paranoiac and schizophrenic reactions, and once again trace each of these from its origins in "normal" behavior to its clinical extremes of intensity, persistence and social incompatibility.

#### Deviations of Affect

Certain diurnal (K. Brown) swings of mood (e.g., morning "blues"), premenstrual anxieties (T. Benedek) or other physiologic seasonal dysphorias (Peterson) are possibly correlated with hormonal rhythms; however, there are nearly always subtle psychologic admixtures—e.g., monthly "cycles" of increased social, charitable or religious activity in

women who sublimate periodic sexual tension. The clinically important dysthymias shading from borderline through neurotic to psychotic may be reviewed as follows:

### Hyperthymic Reactions

*Euphoria.* At first sight, true euphoria would seem to be rather desirable, since the term is generally taken to connote a persistent cheerfulness, a heightened feeling of wellbeing and an unabashed or even obtrusive optimism. Although this state should be distinguished from the quiet, undemonstrative equanimity (literally "balanced spirits") and happiness of the truly contented individual, it is obvious that mild euphoria is hardly likely to be regarded by the patient as a condition requiring psychiatric treatment. Much more often seen by the psychiatrist, then, is the pseudo-euphoric who subtly senses that his mimetic ebullience and forced gaiety would quickly vanish should he stop compulsively trying to be "cheerful" and face his problems directly. In most cases it is not difficult to discern the tensions underlying the frenetic hyperactivity of such individuals who, in restless flight from their anxieties, occupy every moment with work, theaters, athletics, sexual affairs, travel and countless other crowded activities—all performed with professed gusto but actually with thin enjoyment and little satisfaction. This often holds true for the exaggerated euphoria and hyperactivity that characterize hypomanic states severe enough to require institutionalization. The following case is an instance.\*

**CASE 42. Hypomania (DSM II 296.1).** A wealthy executive, forty-eight years of age, was brought to the hospital by a business associate who stated that the patient "had been running himself so ragged with too much work and too much play" that his friends had insisted that he come to the hospital for a "check-up and a rest-cure." Further questioning revealed that for the preceding four months the patient had been working intensely but erratically, making quick business decisions that sometimes produced brilliant results, but as often proved unsound and unprofitable. Moreover, his social behavior had become impulsive and unpredictable; for instance, he had twice abruptly adjourned business conferences in the midst of serious work with a sudden invitation to everyone present "to quit, have a drink, and come play golf at my club." On the first occasion a few present had goodnaturedly accepted, but while he was driving them to the golf course the patient suddenly expanded his invitation to include a complete weekend for everyone at his country home two hundred miles away, and had with difficulty been dissuaded from heading there immediately. In his executive capacities he continued with similar impetuosity, arranging unnecessary trips and conferences and proposing extravagant

\* Cases in this chapter have been selected to illustrate clinical semeiology and psychotherapy. Pharmacotherapeutic and other modalities will be detailed in a later volume.

promotional schemes; similarly, in his entertainments for the firm's customers, his restlessness, unnecessary lavishness, excessive drinking and forced gaiety had been increasingly embarrassing to his friends. These insisted, however, that the patient had previously been a sober, stable and rather undemonstrative individual.

In the hospital the patient's behavior was characteristically pseudo-manic. He dressed in flashy pajamas and loud bathrobes, and was otherwise immodest and careless about his personal appearance. He neglected his meals and rest hours, and was highly irregular, impulsive and distractible in his adaptations to ward routine. Without apparent intent to be annoying or disturbing he sang, whistled, told pointless off-color stories, visited indiscriminately and flirted crudely with the nurses and female patients. Superficially, he appeared to be in high spirits, and yet one day when he was being gently chided over some particularly irresponsible act he suddenly slumped in a chair, covered his face with his hands, began sobbing, and cried, "For Pete's sake, doc, let me be. Can't you see that I've just *got* to act happy?" This reversal of mood was transient and his seeming buoyancy returned in a few moments; nevertheless, during a Sodium Amytal interview his forced euphoria again dropped away and he burst into frank sobbing as he clung to the physician's arm. He then confided that during the preceding year he had begun to suspect, with some reason, that his young second wife, whom he "loved to distraction," had tired of their marriage and had been unfaithful to him. He had accused her of this, and she had replied, almost indifferently, with an offer of divorce. His pride had been greatly wounded, but to salvage it, avoid the scandal of a second divorce and keep her as long as possible he had agreed that she take an extended European tour and postpone her decision until her return. During her absence he had been obsessively torn by suspense, jealousy and anger, could no longer take an interest in his work and had lost sleep, strength and weight. He consulted his family physician for the latter symptoms, but the doctor, after finding little physically wrong with him, had simply advised him "to forget your business [sic] troubles, play a bit more golf, get about more and enjoy yourself." He had followed this advice with compulsive intensity, but with the abreactive exaggeration that had eventually led to his admission to the hospital.

Needless to say, this account by the patient as to the reasons for his disturbances of mood and behavior was far from complete, but served to initiate further confidences in later interviews. Thus, the patient confessed that during the past several years he had begun to feel that his place near the head of a business concern was being threatened by younger, more energetic and better-trained men, in competition with whom he himself had thought it necessary to become ultra- "progressive" in his executive tasks. In private life, too, he had become afraid of being considered "just a nice old has-been," and had therefore begun to indulge in drinking, athletics, and exhibitionistic stag-party venery which he didn't really enjoy. But perhaps his greatest defense against his obsessive fears of obsolescence had been his second marriage to a young, pretty and popular girl whom he had, by offering her a life of wealth and ease, won away from more youthful admirers. The patient unconsciously prized his wife as a symbol of his own renewed youth; unfortunately, in his anxiety to prove his sexual competence, he had frequently been impotent with her, and had then made their marriage almost intolerable by his

reactive rages and jealousies. As a result, she had very probably become unfaithful and was currently spending more of his money in Europe in anticipation of an eventual divorce.

Under a regimen of rest, mild sedation (lithium was not administered), physiotherapy and gradual working-through of his emotional difficulties in individual and group sessions over a period of a month, with interim extramural departures to tend to his business, social and marital affairs, the patient's hypomanic tension rapidly abated, and he regained confidence and competence and maintained them with only occasional follow-up interviews during a two-year period.

**Mania.** In "true mania" overwhelming tensions may be expressed in extreme distractibility, a continuous flow of ideation and speech with rapidly changing context, a furor of exhibitionistic and other uninhibited activity, and a highly labile emotional tone. In most cases these reactions abate spontaneously after several weeks or months, but in some instances the patient's behavior may become chronically disorganized to produce the "delire chronique" of Charcot or the "chronic mania" of Schott.

#### Hypothymic Reactions

Depressions or melancholic fixations of mood, unlike pseudo-euphoric states, are more directly allied with anxiety and more overtly charged with suffering, and yet they too can be shown to have certain adaptive functions. Thus, at the physiologic level the usual accompaniments of a depression are; insomnia, anorexia, constipation and motor tension sometimes accompanied by restlessness or agitation—symptoms that might be expected to occur in an individual watchfully mobilized against what seems to him to be a hostile and threatening world. Other depressive symptoms also have their symbolically defensive overdeterminations: impotence or amenorrhea unconsciously signify a surrender of adult genitality; petulant helplessness, passivity and dependency connote a regression to infantile emotional orientations; and fixed hypochondriasis is only a thinly veiled reversion to narcissistic and auto-erotic concern with the patient's own body. The ideational content of the depressive, too, is symbolically significant; exaggerated self-accusations (e.g., "I am the greatest sinner that ever lived, and all the world knows it") seem to express ideas of extreme guilt and unworthiness, yet at the same time reveal the patient's tendencies toward perversely paranoid and delusional self-aggrandizement. Again, while the retarded and depressed patient is evidently far from comfortable in his reactions, his behavior often enough seems almost deliberately though subtly aggressive toward those (usually members of his family) against whom he had deep but repressed hostilities. Finally, at even deeper levels, primitive "introjective symbolisms" may occur: the melancholic who fears

he "has lost everything" may develop schizoid delusions that he "has swallowed the world," or, conversely, that through suicide he can destroy only his suffering physical body, while retaining some form of being as an immortal "spirit" who would (b) punish his earthly persecutors, (c) be rewarded in Heaven, and (d) perhaps even be reborn to a more appreciative world. Such fantasies are, of course, difficult to elicit even in psychotic patients, but variants of them are illustrated by the following case:

CASE 43. *Melancholia*. An intelligent, but physically rather unattractive Catholic schoolteacher married secretly at the age of thirty-eight and a year later became pregnant. Her husband, an improvident, middle-aged ne'er-do-well, did not like the prospect of the patient losing her position if her marriage were discovered. He therefore strongly urged her to have an abortion; when she refused, he deserted her. This left the patient no alternative but to violate her religious scruples and attempt to abort herself, not only to keep her job and social position but to remove all memories of her unhappy marital experiences. But her crude attempts failed, so that the patient was forced to reveal the date and fate of her marriage to her family. On their advice—tinged with considerable covert condemnation—she obtained a leave of absence from her job and reversed her conscious attitude toward her pregnancy; in fact, she began to plan with ominously overcompensatory zeal for every detail of the immediate and remote future of her child, on whom she intended to focus her "every remaining interest in life." She was delivered normally at term but, again tragically, the child was congenitally deformed and died within a few hours. The patient almost immediately entered into a deep melancholic state in which she refused to eat, slept fitfully or not at all, lost twenty pounds of weight in as many days, and needed mechanical restraints to prevent suicidal attempts. The acute phase gradually passed, but for months of institutionalization thereafter she had to be nursed, washed, dressed, spoon fed and cared for as though she herself were a child. During this period she seemed to have lost all her former intellectual and social interests; she could not be induced to read, listen to news or music, or engage in occupational or group activities. After visits by her family, she was particularly querulous and demanding; at other times she sat rocking to and fro, chanting to herself in an almost inaudible, repetitious sing-song in which the following content could sometimes be distinguished: She accused herself of having committed the "Unforgivable Sin," the nature of which she never further specified. The Catholic Church and all its clerical hierarchy had been informed of this. Indeed, the Holy Trinity Themselves had condemned her to eternal perdition, and this was a universal catastrophe, because she herself had become "Mrs. Pope Pius XIV," and even now her womb was "pregnant with a Holy Child" which had to be guarded and protected eternally. These bizarre and self-excoriative fantasies were charged with an intensity of affect difficult to describe but immediately sensed as deeply melancholic by nearly every observer. And yet, despite her apparent suffering, the patient concentrated into her melancholia a wealth of defenses that seemed economically essential if her anxiety was to be made bearable at all. Ostensibly the patient condemned herself as a lost soul, automatically excommunicated

cated from the Church because of her "unforgivable sin"—her attempt to murder an unborn child; however, at the same time, she compensated for this guilt by the grandiose and subtly self-preserving fantasy that the entire Church was concerned with her particular conduct. Further, her punishment would be supervised by the Heavenly Court itself, Who, in view of her exalted position as the "wife" of a future pontiff, might eventually condone her transgressions and grant them absolution. Similarly, while she confessed her previous wishes for the death of her unwanted baby, she overcompensated for these by a delusion of possessing a deathless child forever reincorporated into her womb. Finally, in her external behavior she made herself actually a helpless being who required all the care and protection of a newborn infant in the midst of a loving and forgiving foster family.

*Comment.* It may be seen that even frankly psychotic behavior patterns, whether depressive or schizoid, are not, as is sometimes inferred, merely shapeless fragments from a personality shattered by some hypothetical "mental disease"; on the contrary, the psychosis itself is an integrated syndrome which, however socially deviant, is adaptively operative at all "levels" from the physiologic to the most abstrusely symbolic.

### Regression

By regression is meant the readoption, under circumstances of deprivation, frustration or conflict, of behavior patterns associated with earlier and more satisfactory experiences. Normally, this may mean a strategic retreat from current stresses into previous modes of thought and conduct, followed by a redirection of energies into new experiences and explorations until, by trial and error, more satisfactory adaptations are found. As a borderline example, a man who is dissatisfied with a contentious and unsuccessful marriage and who longs for his premarital freedom might act as though he were again a bachelor—by not supporting his wife, keeping his own hours and having extramarital affairs; nevertheless, whatever our moral judgments, the man could be said to show *regressive character traits* only if, after divorce and remarriage to a more deserving woman, he continued such patterns and showed no tendency to resume mature habits of responsibility and self discipline.

*Neurotic Regressions.* These usually denote a reversion to much earlier (i.e., childlike or infantile) patterns of conduct rather than a retrial of other relatively mature ones. Obviously, there are no really sharp demarcations among the various dynamic "stages" of "normal," neurotic or psychotic regression, since not even in the psychoses is there a literal reenactment of early conduct, totally unmodified by residues of later experience. Every person tends, consciously or not, to readopt puerile patterns when faced with severe disappointment, disease or other serious

threat to his well-being. Certainly, every physician, attorney and minister soon becomes familiar with the fact that those who come to him physically, socially or spiritually in trouble approach him with the same plaintive dependence with which a child unloads its burdens on a trusted parent. Regressive ambivalences, as we have seen, become particularly evident in the process of psychoanalysis and may then have the specific content of the mixed loves and hatreds which the patient previously felt toward his parents and which are now "transferred" to the analyst. However, equally frank manifestations of regression may be observed outside the analytic process if the emotional stresses become sufficiently great. The war furnished many examples, which could be typified as follows:

CASE 44. *Psychotic regression (295.0)*. A seventeen-year-old girl (Plate I-A) was brought to a psychiatric clinic by her mother with the complaint that for the preceding five months her behavior had become increasingly irrational and destructive. The history revealed that after the patient was about four years old, her parents had begun to quarrel violently, making her early environment extremely contentious and unstable. At about this age she first developed various neurotic traits: nail-biting, temper-tantrums, enuresis and numerous phobias. When the patient was seven the mother refused further sexual relations with the father and left the marital bed, but the patient continued to sleep with the father until she was thirteen. At this time, the mother suspected that the patient was being incestuously seduced, obtained legal custody of the girl and moved away with her to a separate home. The patient resented this, quarreled frequently with her mother, became a disciplinary problem at home and at school and acquired a police record for various delinquencies. Three years later, at the patient's insistence, she and her mother paid an unexpected visit to the father, and found him living with another girl in questionable circumstances. In a violent scene, the mother denounced the father for unfaithfulness and, again contrary to the patient's wishes, took her home. There the patient refused to attend school and rapidly became sullen, withdrawn and noncommunicative. During her mother's absence at work, she would keep the house in disorder, destroy clothes her mother had made for her, and throw her mother's effects out of the window. During one of these forays she discovered a photograph of herself at the age of five (B), which, incidentally, was so poorly lighted and faded that, for one detail, it did not show her eyebrows. Using this as a pattern, she shaved off her own eyebrows, cut her hair to the same baby bob, and began to simulate the facial expression and sitting posture of the pictured child (C). When brought to the hospital her general behavior was correspondingly childish; she was untidy and enuretic, giggled incessantly or spoke in simple monosyllabic sentences, spent most of her time on the floor playing with blocks or paper dolls, and had to be fed, cleaned and supervised as though she were an infant. In effect, she appeared to have regressed to a relatively desirable period in her life antedating familial conflicts and disruptive jealousies; moreover, she acted out this regression in deliberate, strikingly symbolic patterns of eliminating the mother as a rival and regaining the father she had lost in her childhood.



A



B

C

PLATE I. The Symbols of Regression (v. Case 44). Thanks are due to Dr. John Romano, Professor of Psychiatry, University of Rochester and to Dr. Richard Renneker for providing these photographs. Reproduced from Masserman, J. H.: *Principles of Dynamic Psychiatry*, ed. 2, 1961, pp. 70-71, with the kind permission of W. B. Saunders Co., Philadelphia, Pa.

CASE 45. *Acute regression; combat neurosis (295.4).* A soldier, normally well disciplined and self-reliant, but subjected overlong to physical exhaustion and the unremitting hell of combat and carnage in the ever-present shadow of death, eventually reached his limit of tolerance and thereafter showed a gradual dissolution of adult habit patterns and an accelerating return to childlike and then infantile conduct. First, his military interests and activities became dulled and his affective reactions progressively more labile and primitive; concurrently, he began to neglect habits of personal hygiene, even to the point of careless evacuation and soiling. Next, he became preoccupied with hazy dreaming of the comforts and security of his own home; finally, in sudden desperate denial of all mature considerations of prestige, duty, discipline or even physical danger, he abandoned his weapons, cried out against all about him and fell to the earth sobbing piteously and inconsolably for his mother. During this extreme reaction, threats of further discipline or even death were useless; the soldier had to be evacuated as a psychiatric casualty, permitted for the time being to cling emotionally to a kindly therapist as a parent-surrogate, and thereafter treated by every means at hand to restore his self-confidence, his group loyalties and his normal defenses against anxiety to prevent his regression becoming fixed at the level of phobic, helpless passivity.

In military psychiatry, reactions such as these are relatively frequent (A. Glass) and their accompanying regression may take a rapid course from premonitory to acute stages; fortunately, however, prompt and skillful treatment may reverse the process. In civilian neuroses, except those occurring after catastrophes, regressive behavior is less extreme, but more chronic and more subtly intertwined with other neurotic manifestations. Moreover, the secondary regressive gains of the neuroses, such as relief from onerous responsibilities, repression or deviation of aggression and the attainment of protective familial or other care, are less easily controlled than in military practice, and therefore make the treatment of chronic civilian neuroses usually more complex and difficult.

*Psychotic Regression.* This term is used when the regressive processes have become deeply fixated, bizarrely symbolic, highly disruptive to the social functions of the patient and almost completely unapproachable by ordinary therapeutic means. Examples of such extreme stages of regression may be seen by the thousands in the back wards of mental hospitals: patients who, whatever the original diagnosis of their psychosis, have "deteriorated" into infantile habits such as thumb-sucking, soiling, disinclinations to clothe and feed themselves, polymorphous auto-erotic activities and almost neonate helplessness (v. Cases 44 and 45); however, this "deteriorative" process does not imply organic cerebral degeneration.

### Schizophrenic Dynamisms

Finally, there is open to the personality under extreme stress an *ultima Thule* of reactions that are usually grouped under the term *schizophrenia*. As will be seen, these may forestall complete disintegration, but, to use a tactical analogy, they are accompanied by the shattering of so many previous defenses, the loss of so many useful forces or so great a retreat and containment that, from the standpoint of reality control, the conflict may often be regarded as having been almost irretrievably impaired. These final schizophrenic maneuvers may be considered from a dynamic and developmental standpoint under the following headings:

#### **Withdrawal from "External Contacts"**

As we have seen, very serious adaptational traumata may occur in the first few years of childhood and may be exacerbated by the physiologic and social stresses of puberty. A child may therefore begin to withdraw from a world he interprets as frustrating and hostile at an early age, and to show an accentuation of this withdrawal into circumscribed narcissistic isolation in fantasy and action during the increased stresses of adolescence—a syndrome that led to the Kraepelinian term, "dementia praecox." In early life, this introversive retreat may take the form of a lack of interest in, or the loss of previous contacts with, parents, siblings, playmates, school, hobbies, sports and other socializing activities; later, the generalized constriction and "autistic" withdrawal, especially in those intellectually endowed, may be signalized by an ominously exclusive preoccupation with one narrow field of interest which prejudices a progressive, rounded development of the social personality. This may first appear as a marked ambivalence in interpersonal relationships, so that the patient is by turn uneasily affectionate or tensely aloof; later he may show strained, explosive deviations of affect and progressive "interpersonal distancing." Concurrently, there may be an insidious or rapid dissolution of learned social customs and amenities, e.g., in habits of sleep, diet, study, dress and cleanliness. Libidinous expressions are apt to show corresponding aberrations: tumultuous, headlong infatuations, dreamy overidealism, or guilt-ridden asceticism leading eventually to a distortion of all social transactions. During various stages of this process those with whom the future schizophrenic comes in contact begin to sense his suspicious isolation and remoteness, and their own unconsciously defensive reactions serve to accelerate his withdrawal. Unfortunately, by the time psychiatric aid is sought there may have been established so great a breach in all interpersonal relationships that a therapeutic transference and rapport can be gained, if at all, only with the greatest skill and patience.

**Blunting and Distortion of Affect**

It is, nevertheless, impossible for a person to exist completely walled off from all external impressions, and some of these must necessarily penetrate even the most deeply fortified self-isolation. To ameliorate the anxiety accompanying such apperceptions, the schizophrenic may either deny their personal significance, or invest them with a distorted or less painful affective charge. The first process produces what is usually described as "emotional shallowness" or "emptiness," whereas the second characterizes "the schisms between thought content and affective tone" that give schizophrenia ("split mind") its graphic name.\* These phenomena, like the peculiarly impenetrable resistance of the schizophrenic to attempts at interpersonal communication, are much more easily learned by clinical experience than from didactic description, but the following example may serve to illustrate some of the typical patterns.

**CASE 46. Schizophrenic distortion of affect (295.7).** A fifteen-year-old girl was brought into the hospital by her parents, who stated that she had been sent home from a preparatory school with the recommendation from the school physician that the parents consult a psychiatrist for "a serious nervous breakdown." The patient was at first noncommunicative, and since the parents had not been observant and were now evasive, the history of the patient's illness was obtained only in fragmentary form. However, as finally assembled from all available sources, including the patient's former physicians and schoolmates, the anamnesis was substantially as follows:

The patient's father was a successful lawyer, whose political and other connections kept him in a continuous round of travel about the country. The patient's mother had artistic pretensions and, since she was wealthy in her own right, she continued to be preoccupied with the organization of clubs, exhibitions, artists' benefits, and other such activities. The marriage of the patient's parents had been a socially convenient, almost loveless affair, but since they each led a fairly full life, they needed each other little and had few clashes of interests. There had therefore been few overt quarrels between them; on the contrary, they both liked to think of their marriage as a model of modern "compatibility" between two "emancipated" people. Unfortunately for the patient, this superficiality of her parents' marital relationships and the diversity of their outside interests frustrated her needs for security and warmth in her early formative years; nor were her longings in this respect satisfied by a succession of children's maids, governesses and nursery schools. Similarly, the child was raised with the best of medical advice, but despite regulated diets and multiple immunizations, she fed poorly, was inactive and remained sickly and underweight. Moreover, she became what the parents called a "delicate and very

\* Proposed by Blueler, who correctly pointed out that, since schizophrenic reactions neither led to inevitable dementia nor necessarily occurred only at puberty, the Kraepelinian term *dementia praecox* was an inaccurate generic designation for all such processes.

sensitive child," subject to night terrors, episodes of morose stubbornness and impulsive attachments or aversions. A particularly illuminating instance of the nature of these reactions occurred on her seventh birthday. The parents had given her an elaborate children's party, with many presents, including a set of expensive sleeping dolls, and had also promised her that they themselves would "now stay home with her for a long time." The next day, however, they each again departed on separate trips, with the sole explanation that they had made the promise "so as not to spoil the party." On their return about a week later they found that the patient had destroyed all of her dolls, forcibly taken a ragged one from a neighbor child, and insisted on keeping this doll with her wherever she went. Soon thereafter the patient developed enuresis and an accentuation of her night terrors, which were now no longer mitigated by the increasingly impatient reassurances of her parents or nurses.

Various medical and dietary treatments for these symptoms were tried without marked success, until a physician advised "a change of scene for the child." The patient was therefore sent to live with her paternal grandparents—a kindly, though somewhat senile couple who, ignoring the parents' advice, "spoiled" the child and permitted her various indulgences, including permission to sleep with them. The enuresis and night terrors abated after several months, but the child developed peculiar dietary habits and continued to have moods of abstraction, during which she would chant ditties of nonsense syllables while repeating apparently meaningless gestures and poses.

After nine months' stay with her grandmother, she was returned to her own home because of a circumstance that her family tried to keep completely secret: the grandfather, after several outbursts of violence, had had to be committed to an institution, for paresis. The family, worried that the patient might have "caught syphilis" from her grandfather, arranged for her to have another series of physical examinations. It was during these that the first definitely psychotic disturbances were noted: the child showed abject terror at the approach of the physician, and, when forced to undergo the examination, entered into a semi-stupor, in which she seemed not to hear, could not be made to speak, and would partially retain any posture in which she was placed. Somewhat later, the family gathered various bits of information that indicated that the child's repetitious miming and her terror of the physical examination dated from various sexual abuses to which she had been subjected by the grandfather. In any case, the patient's *pavor nocturnus* and spells of immobility, mutism and unapproachability became more frequent and alarming. A nonmedical "child expert" and various physicians were again consulted, but no diagnosis was reached other than that the child possibly had a disorder of the thymus gland, which, it was hoped, she would eventually "outgrow."

Since the patient could not be sent to either a public or private school because her behavior might elicit comment and gossip unfavorable to the family, a private governess was obtained for her. Fortunately, this individual was a warm, maternal woman who took a genuine liking to the child, and the latter in turn began to reciprocate her affection. After some months the patient began to take an interest in her studies and to learn quite rapidly. During the next three years, moreover, she also

acquired increasing spontaneity, interest and ease in her interpersonal relationships, although, again to guard against scandal, her extrafamilial contacts were guarded and kept at a minimum. A setback occurred at the time of her menarche, when it was discovered that she had been so frightened by the onset of her periods that she had worn rags and washed her own underclothes for months without daring to tell even her tutor.

Nevertheless, in view of her seeming improvement, when she was fifteen the parents decided to send her to a private seminary for girls. The patient showed neither enthusiasm nor overt resistance to the plan, and accompanied the family docilely to the school. However, "matriculation" (in the symbolic sense of establishing an emancipatory relationship to an "alma mater") was completely unsuccessful: she developed no interests in her teachers, her work, her associates or in the school activities, and when she was pressed to fulfill even the minimal requirements, her behavior again deteriorated rapidly. As reported by the principal she became increasingly awkward and shy, frequently sat vacant and unheeding in her classroom, began to mark her books and papers with strange designs, and became subject to sudden outbursts of peculiarly unemotional weeping or laughter with no apparent provocation. One cold night she was discovered wandering about the campus in her nightgown, and, when questioned, told an almost incoherent, strangely unconcerned story of how her roommates had burned the dormitory down because God Himself had told them the housemother was wicked. The patient was returned home and soon afterwards admitted to the hospital.

On the observation ward her behavior was quite evidently abnormal. She waved her hands, blinked her eyes and tossed her head in bizarre repetitive gestures, interrupted by periods of blank immobility. She would not wash her face or body because "they might wash away," but would comb her hair for hours if permitted to do so. She refused to speak to any of the nurses, whom she identified as "delegates from the school," and would talk to the psychiatrist only after he removed his spectacles so that he "could not look right through" her. She was perfectly oriented for time and place, yet she stated with little apparent concern that the hospital call system was broadcasting her thoughts in Morse code "to all nurses," and that she was certain to be "brexed" (a neologism apparently compounded of "bruised," "raped" and "sexed") unless the "FBI lawyers," who were then mobilizing, were summoned to her rescue by the "Queen Mother." In any case, the psychiatrist, too, was "a good lawyer" and would help her—in fact, he must do so, since she had deliberately touched the marriage ring which he wore. The latter fantasy appeared again and again, and was often accompanied by a brief series of tearless, empty, tic-like sobs.

Unfortunately, the patient's parents, horrified and humiliated by "insanity appearing for the first time in our family," showed their hostilities toward the child even more clearly by demanding that she be given "modern shock therapy" immediately. They remained adamant in refusing to listen to explanations that, at this stage, drastic treatment would in all probability permanently harm the patient, and after a week removed her from the hospital.

*Comment.* This case illustrates a number of schizophrenic dynamisms—among them “concretization” of fantasy and spread of symbolism (e.g., the psychiatrist’s ring, which allied her with her “lawyer” father), *projections* of her own impulses onto others (“the girls—not I—wished to burn the dormitory down”), defensive ego-aggrandizement in the face of deep anxieties (I am the object of concern to the “FBI” and the “Queen Mother”) and, finally, an almost impenetrable narcissistic isolation from realistic interpersonal contacts. But perhaps the most outstanding feature was the defensive numbing of the patient’s affective reactions: fears, rage and laughter were displaced or dissociated from their real or fantastic context, and lost their poignancy in a shallow travesty of true affect.

### Thinking Disturbances in Schizophrenia

The example cited may also serve as an introduction to the distortions of thought processes common in schizophrenic reactions. These may be considered dynamically under the following headings:

*Reorganization of “Categories.”* As we have seen, every individual, “abnormal” or not, has his own set of experientially contingent “categories” of time, space, sequence and “causality”; in fact, it is an age-old metapsychologic question whether the parameters used by any two persons exactly agree, or whether any set can be shown to correspond with a postulated “reality.” In addition, the subjective categories of an individual vary widely with changes in his psychobiologic status: for example, his distinctions and groupings of phenomena will be changed by accumulating experience; his “reasoning” process will depend on prejudices modified by the circumstances and mood of the current moment; his time “drags” when he is alertly anxious and “flies” when he is contentedly occupied; a tiny dental cavity, ordinarily imperceptible to his tongue, seems to grow to enormous proportions when the tooth begins to ache, and all concepts and their relationships are greatly altered by toxicity or the neurologic deficits and reorganizations resulting from a cerebral lesion (Goldstein, Brickner et al.). But the schizophrenic, unable to abide even the usual approximations by social agreement as to time, space and causality, reorganizes his world into startlingly different categories. Beginning, perhaps, with distortions of his own body image and vital tempo (Schilder), he changes his conceptions of time, space and logical order, and either reconstitutes their relationships or frees himself of their confines altogether. This process may be seen in psychodiagnostic tests (cf. Vol. I, Chapter 6); for instance, the schizophrenic will make highly unusual images out of the white spaces or minute details of the Rorschach ink-bLOTS, instead of seeing the large black figures “obvious” to everyone else. Similarly, when asked to arrange

wooden blocks by color, size or weight, a schizophrenic may group them instead by fantastic criteria of his own, e.g., blocks which are "good soldiers" as distinguished from "wicked" ones (Hanfmann and Kasanin). Nor need even the dimensions of "normal" orientations such as those of space, time, quality or value remain discrete; on the contrary, these are mutually transmutable in his solipsistic universe, into which further experience can enter with difficulty, and only when clothed with markedly deviated symbolization and significance. Such schizophrenic aberrations of ideation and "reified" fantasy are then reflected in the striking symptoms that characterize the clinical course of the psychosis.

*Sensorial Disturbances.* Since the schizophrenic, remote from external "reality" and unmindful of social consequences, acts in accordance with his distorted affect and ideation, his behavior appears to others to be characterized by *illusions*, *hallucinations* and *delusions*. These may be considered from a dynamic standpoint as follows:

### Illusions

These are perceptual "misidentifications" of the sensory field, and as such they may range from the everyday and accepted "normal" to the grossly deviant phenomena seen in toxic states. Gestalt psychology has demonstrated that we "normally" perceive stimuli as we become accustomed to categorize them: we "close" gaps to produce comfortably "whole" figures; we prefer to reconstruct known geometric patterns when an infinity of choice is possible (e.g., a penny is seen as "round" from any angle); we "recognize" indeterminate pictures of persons and scenes, and so on; in other words, we organize our sensory perceptions according to certain experientially predetermined "sets." Here again, however, biodynamic factors play a prominent role. For instance, in the "hypnagogic" state between sleeping and waking, illusions are easily produced and given momentary credence: the room may appear inverted, with the body suspended in mid-air; objects may seem to breathe or move in capricious fancy; time stands still, or is accelerated, or reversed. Should orientation, organization and other corrective "judgments" be concurrently impaired by drugs or toxins, such illusions may become continuous and exceedingly fantastic; e.g., the wall-paper design becomes filled with talking faces, or the chandelier a dangling gallows. Finally, with an extension of such apperceptual deviations channelized by wishful and dereistically symbolic thinking, the schizophrenic may "recognize" his dead mother's voice in the clatter of the hospital food-cart or "see" his wife in the smoke outside the window, or "feel the radio waves sent out by the Masons" in the prickle of his bed-clothes.

### Hallucinations

These are percepts formed without any readily apparent "external" sensory stimuli. In dreams, such fantasies are partially freed from the sensorial and repressive inhibitions that control waking consciousness, and the universe is hallucinated in wishfully determined symbols; in fact, for a short period after waking, "actual" reality may seem for a time the stranger of the two. In the psychoses, this socially required reorientation to an inimical reality is rejected—a circumstance that led Bleuler to characterize schizophrenia strikingly as a "waking dream" in which elemental wishes break through into hallucinatory and delusional behavior, with only a thin veneer of displacements, condensations, projections and other defensive symbol-associations. A brief illustration may suffice:

**CASE 47. Schizophrenic hallucinations (295.99).** A twenty-three-year-old woman with a markedly schizoid personality, paranoid tendencies and precarious "reality" adjustments was informed by her husband that he was soon to be drafted into the army. She reacted with feelings of deep insecurity and fantasies of regression to former sexual, familial and other relationships. Two days later she asked him if it was not possible that his selection had been "arranged" by a girlhood paramour of hers who had "fixed" it so that he could in this manner have the patient for himself. The husband, busy with his army induction, dismissed this as just a bit more bizarre than her "usual queer ideas", and departed on schedule. Soon, however, the patient began to detect a peculiar taste in her food and noted that she was continually aroused sexually; this confirmed her suspicions that her paramour was drugging her food so as to seduce her. One morning a week later, after an erotic dream, she awoke to "see" this man "leering" into her window, and concluded that he had also hypnotized her while she slept. She upbraided him and he disappeared, only to return that afternoon. This time she called the police, who found no evidence of an intruder; however, at her demand, they issued a warrant for his arrest. Fortunately, it was found that the accused had moved to another city several weeks before his alleged attempts at poisoning and seduction. The Red Cross was called in, communicated with the husband at his army camp, arranged for a psychiatric examination of the woman, and supervised her commitment to a private sanatorium.

This case illustrates a function which may in other circumstances be hidden by a more highly displaced and distorted symbolism; namely, that hallucinations are often projected pictorializations of narcissistic, aggressive or erotic conflicts. Since none of the wishes involved can be completely fulfilled without violating one or more of the others, hallucinations, like nightmares, may contain a large element of frustration and anxiety derived from the covert conflict they express. When the integrative capacities of the individual are further impaired by drugs, disease or cerebral injuries, the hallucinations assume the characteristically kaleidoscopic,

disorganized, fear-ridden forms seen in hyperpyrexia, delirium tremens and other toxic states.

### Delusions

These are systems of concepts and beliefs which, though considered irrational by the cultural group to which the individual belongs, are nevertheless necessary to his psychic economy and therefore immune to argument and reason. Delusions may, indeed, be differentiated from the closely related phenomena of prejudices, superstitions and religious fanaticisms only by this criterion of relative rejection in culture and time; i.e., the accepted philosophy of one society is pagan fanaticism to another, and our own common beliefs of today will tomorrow be the residual superstitions of the ignorant. An example of a system of beliefs that today would be considered psychotic by most people, yet was once accepted as self-evident fact follows:

*Cultural Schizophrenia.* In the middle ages it was widely believed that agents of the Devil in the form of incubi and succubi "possessed" and inhabited persons who had made unholy compacts to sell their souls in exchange for earthly power over the devout. An official treatise, called the *Malleus Maleficarum*, was issued during the Inquisition to aid in the detection of such persons, and in it were described in detail certain typical experiences and identifying marks (such as an area of anesthesia outlining a "devil's claw"), by which a suspected "witch" could be condemned. It is a matter of record that many thousands of persons, though obviously psychotic by present-day standards, participated so thoroughly in the beliefs of the time that they freely "confessed" hallucinated experiences with the Devil himself, almost gleefully pointed out the "marks" he had left on their bodies and claimed great powers as a result of these dealings. From the accounts of various Inquisitors it appears that in many cases such delusions, although they made torture and death almost inevitable, yet had their functions; the victim was either convinced of his thaumaturgic powers and immune to the reality of his danger, or he was equally certain that his immolation was only an adventurous step to some other, more desirable non-earthly existence.

So also in later times psychotics have appropriated and distorted the popular beliefs of the day. For instance, in the early nineteenth century, after various misconceptions of "mesmerism" had been popularized, many persons believed themselves to be influenced by some known or unknown "hypnotist" who compelled them to act "against their will"—although it was usually demonstrable that what they were "compelled" to do really expressed their own inhibited and deviated desires. Later, and again run-

ning parallel with popular misconceptions of current physical science, psychotic individuals attributed their hallucinated sensations or experiences to "phlogiston," "magnetism" or "electricity." Today "radio waves," "radar" or even "atomic energy" are the mysterious all-penetrating tools of the nefarious "They," the eternally depersonalized persecutors of the psychotic (cf. Plate II). In this way, delusions, though they constitute a distortion of "reality," nevertheless reveal an indissoluble residue of the individual's experiences and culturally conditioned interpretations.

In the unconscious dynamics of the individual, delusions, like other sensorial aberrations, subserve a number of interrelated *projective economic functions*: for instance, delusions attribute to other persons one's own inadmissible desires or ideas (*projective identification*); they blame others for "causing" one's own conduct (*delusions of influence*); they explain irrational behavior on spuriously "logical" grounds (*psychotic rationalization*); they overcompensate for feelings of isolation through fantasies of being the focus of widespread or universal interest and attention (*ideas of reference*); or they counteract inadequacies or inferiorities by a sense of power (*delusions of grandeur, omniscience and omnipotence*), which has its roots in transcendent narcissism. In aberrantly adaptive ways, repressed unconscious wishes and unattainable fantasies, which are then organized into delusional formations. Nevertheless, the break with cultural norms is rarely absolute even in crystallized schizophrenic reactions, as the following case will illustrate:

CASE 48. *Schizophrenic delusions* (295.3). Wanda Viaszinska,\* the daughter of intelligent and cultured Czech immigrants, came to this country at the age of eight and was raised in a marginal slum district where her father, though an excellent artisan, eked out a poor living in his metal-working shop. Her older brother, a handsome, energetic lad, was the parents' favorite, and received whatever indulgences the family could afford; e.g., he was supported through high school and into college, while the patient had to work to contribute to her own and her family's support. Wanda, too, was sent to a parochial and later a public high school where, by dint of her facile intelligence and application, she made excellent grades during the first two years. However, since her extracurricular time was so completely occupied and also because her early training had made her shy, hesitant and self-effacing, she cultivated few social activities and no friends. Instead, her only interest lay in the secret writing of highly dramatic novelettes and plays. The favorite heroine in these productions was a poor but talented and beautiful girl who, despite various buffettings of fate, finally won fortune and acclaim for some artistic masterpiece. In a peculiarly ambivalent reaction to her family, she became increasingly ashamed of

\* The patient's name is of course disguised in this presentation.

her "un-Americanized" parents and her poor home surroundings; conversely, she professed great pride in her popular and successful brother, especially when he became a volunteer Air Force cadet. But this pride, too, was a private affair; after his departure from home, she became all the more reserved and solitary, and, when otherwise unoccupied, began to indulge in long and fanciful daydreams, usually as to how she would become a nurse, join her brother in the American military forces, liberate Czechoslovakia from Russia and herself become a world-renowned heroine. The parents were not unobservant of her progressive isolation and social desuetude and finally insisted that she stop working after school in order to have time for normal recreations and social contacts. The patient compromised by devoting her free time to volunteer war activities, but again selected solitary tasks such as folding and addressing civilian defense circulars at home. Other peculiarities of behavior appeared which indicated a developing delusional context: for instance, the patient suddenly decided to change her Slavic surname of Viaszinska to the Anglo-Saxon "Wallace," and thereafter became infuriated if anyone used her original name. The patient went out on a few dates on her parent's insistence, but compared her companions openly and unfavorably to her idealized brother, violently resented their tentative sexual advances and soon dropped further contacts in this direction. Her grades during the last year of high school dropped rapidly as her work became disorganized and fragmentary, but although a few of her teachers noted the patient's growing peculiarities, she was lost in the mass-education "platoon system" of the school and given no individual attention or guidance.

The break that precipitated her frank psychosis occurred under these circumstances: one day the family received word that the patient's brother, far from making a success in the Air Force, had actually been responsible for a serious accident, and had been dismissed from training because of recklessness and incompetence. The patient's reaction to this news was definitely abnormal; she assured her parents that although the notice received was "possibly a joke," it was more probably the Government's test of their loyalty and patriotism. Two days later the patient suddenly announced during a recital in class that her brother was now the leading air ace of the war, and supported this assertion by displaying a newspaper bearing a photograph and description of a flyer who in no way resembled her brother. When these discrepancies were pointed out to her by an astonished teacher, she explained them in a mysterious, disconnected manner on the basis of "military secrecy" and asserted further—but with little emotion—that Soviet spies who were in conflict with "American pilgrims" were after her at that moment, not only because of her brother, but to prevent her "from writing a book that would give away my information to make Czechoslovakia greater than Russia." Since the patient's behavior was now obviously psychotic, she was hospitalized soon after this episode. By this time her ideation and speech, disjointed or at best frequently blocked, was rendered even more incoherent by occasional neologisms such as "frisgrace," by which the patient apparently meant a combination of "fame" and "disgrace." She wrote long letters to her brother "in the Czechoslovak Air Force," but the manuscripts consisted of criss-cross undecipherable writing and were illustrated by unexplained symbolisms of intertwined lines and forms. One other episode was significant: with great difficulty, the

patient was one day induced to join a group in a simple game of throwing darts at little wooden dwarflike figures. She played mechanically and desultorily until quite by accident she hit one of the male figurines, whereupon she suddenly recoiled, gestured wildly and then fell to the floor in seeming oblivion. Later she explained vaguely that by her act she had not only "knocked her brother from the skies" but had, in some omnipotent manner, injured all fliers everywhere.

*Comment.* An analysis of these and other fantasies and reactions indicated that this patient's delusional system, bizarre and unorganized as it was, nevertheless had specific meanings and subserved definitely compensatory functions. Thus, she displaced her reactive hostility toward her parents onto a condemnation of their "foreign customs" and even their surname, yet indicated her regressive yearnings for reunion with them by her allegiance to Czechoslovakia, her identifications with their favored son, and her rejections of social or sexual emancipations from the home. The brother-symbol at the same time served other purposes: it supported her claims to security in this country (reflected also in her fanatic patriotism, her alliance with "American pilgrims," etc.); it signified her own displaced masculine wishes, and it expressed her overcompensatory desires to rise from rejection and obscurity to fame and power through a delusional idealization of her brother. Nevertheless, her jealousies could not be denied, and they shone through in her literally self-paralyzing guilt when she hit the wooden figure with her dart and so "knocked him from the skies." However displaced and condensed these fantasies were, they still approached too closely to her deepest anxieties and therefore had to be robbed, in typical schizophrenic fashion, of continuity, organization and emotional tone, especially when they dealt with symbolically pressing events.

CASE 49. *Paranoid delusions (297.0).* A forty-year-old paranoiac drew these diagrams (Plate II) of a mysterious "machine" which, he claimed, retrospectively, his "enemies" had been using since his birth to read and control his thoughts and feelings, govern his actions through "hip-not-ism" and "electronic waves," cause him to entertain evil sexual and other forbidden desires, and suffer trances, illnesses or, if they finally willed it, eventual death. The patient's persecutors were vaguely and variously identified as secret police, "astrologers," or supernatural cosmic agents, possessed with an omnipotent influence called "Summa Loqui" (the "highest word"?) but presumably jealous of his own great powers. These delusions evidently served a number of purposes: they replaced feelings of failure and deep inadequacy with fantasies of vicarious self-aggrandizement; they projected his erotic, homosexual and destructive impulses onto others and thus relieved him of responsibility for any counteraction he might take, and, less directly, they made it necessary for him to regress, in effect, to the custodial safety of a psychiatric hospital. The fixity of the patient's basic delusional formations is symbolized by the fact that, although the patient drew many diagrams of this machine, the ground

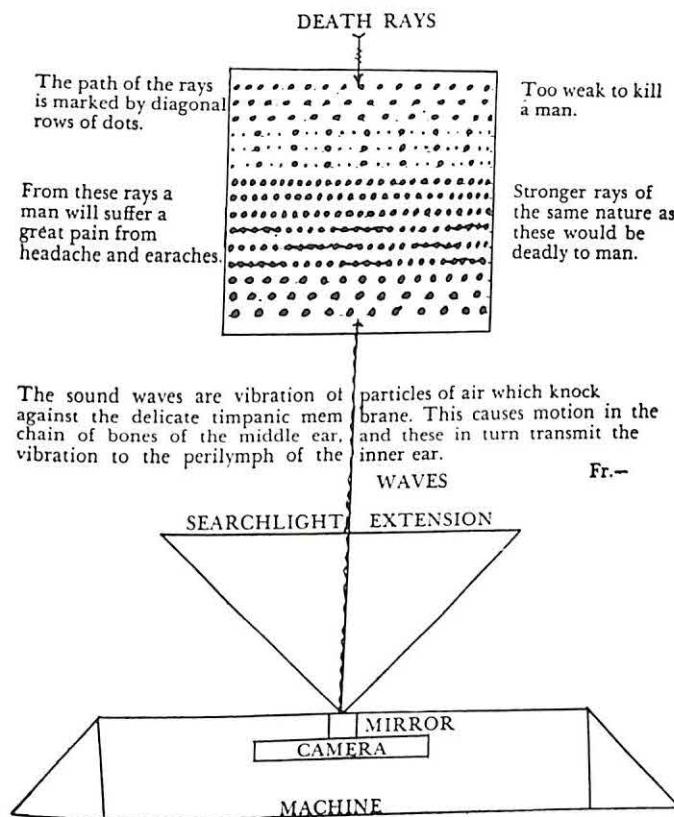


PLATE II. An Influencing Machine (v. Case 49). The author is indebted to Dr. Adrian H. VanderVeer for the material of this Plate. For a psychoanalytic discussion of the concept of an influencing machine, cf. Tausk (1933). Reproduced from Masserman, J. H.: *Principles of Dynamic Psychiatry*, ed. 2, 1961, pp. 82-83, with the kind permission of W. B. Saunders Co., Philadelphia, Pa.

plan of the construction was always the same and the objects it influenced varied only within narrow limits.

#### Disturbances in Motor Patterns

Examples of psychotic motor patterns have already been cited in connection with Cases 43 and 46. Other disturbances particularly associated with schizophrenic reactions may take the following forms:

*Stereotypy.* By this is meant a tendency to fixity (*posturing, attitudinizing*) or repetitiousness of behavior in thought (*autochtony*), word (*verbigeration*) or deed (*stereotypy*). Dynamically, this concentration on one recurrent behavior pattern may serve to exclude other less acceptable ones, whereas the one selected may itself express certain obscure and de-

viated wishes, as condensed either into newly formed words (*neologisms*) or as symbolized by repetitive gestures and movements. The following is a clinical example:

CASE 50. *Schizophrenic Stereotypies* (295.0). A Polish woman who had been in a state psychiatric hospital for two years did little all day but sit humped over a stool repeating the sound "Boligo!" and making a peculiar downward swoop with her right hand, followed by a waving, pushing motion of her palm. Her left arm, which was held motionless, showed a marked atrophy of disuse, whereas the musculature of her right shoulder and arm was hypertrophied from her apparently tireless exercise. The patient would struggle against any interference with her stereotyped motions; if they were forcibly restrained, she would go into a state of mute, semi-catatonic passivity, only to resume her chant and gestures upon release. One day a matronly attendant of Polish origin was assigned to duty in the ward, and, because of their ethnic kinship, began to take particular interest in the patient. The latter responded slowly and suspiciously, but after several weeks began to converse hesitantly in Polish with the newcomer. Through this relationship some history was obtained, in the light of which the patient's behavior could in part be interpreted. Briefly, she had emigrated from Poland at seventeen and had been given no opportunity to attend school or even learn more than a few words of English. Instead, she had been almost immediately apprenticed by her family to a middle-aged tailor, whom she was forced to marry two years later. He had mistreated her from the start and soon after marriage added beatings and various sexual abuses to their relationship. The patient appealed to her family, but their cultural attitude and religious convictions made correction of the situation impossible. The patient's repressed hostilities to her husband and children took various forms, among them an obsessive fear that her cooking might harm them; later this changed to a delusional conviction that she had already poisoned them and was therefore excommunicated from the Church. Unfortunately she was committed to a state hospital where no one spoke her language or gave her any but the barest custodial care; under these circumstances, her habit patterns deteriorated rapidly into the peculiar stereotypes previously described. Symbolically, these consisted of a common Polish word of her childhood, "boli," meaning "pain," combined with the English word "go." This wishful combination "pain, go!" was accompanied endlessly by the sweeping motion of a tailor working his needle (symbolically, her husband), terminated with the palm-outward pushing gesture of avoidance and dismissal.

*Catatonia.* This may be simply a generalized muscular immobility and lack of reaction to stimulation signifying narcissistic isolation and apathy, or it may be accompanied by the phenomenon of *flexibilitas cerea*, by which is meant a tendency of the catatonic to maintain, with seemingly infinite passivity, any posture in which he is placed. Closely allied to this are the relatively rare phenomena of *echolalia* and *echopraxia*, in which the patient "echoes" the words or mimes the action of the examiner and so

seems to make a distant mockery of interpersonal rapport and communication.

In contrast, a *negativistic* patient will resist all manipulation and, if force is used, may attempt to substitute the precisely converse motor pattern. As may be expected, such patients, between periods of relative quiet, are subject to *catatonic furors*, characterized by rapidly changing hallucinations and delusions, wild excitement and violent hyperactivity that may be homicidally or suicidally dangerous.

### PREVIEW OF THERAPY

The pharmacologic, psychotherapeutic and social rehabilitative therapy of the psychoses, will be presented, as noted, in detail with suitable case illustrations in a later volume in this series. Here, however, we may briefly note that the forms of therapy described in Chapters 2-7 for the less pervasive behavior disorders must be modified in accordance with the following objectives:

- (1) To furnish, when necessary, a specially designed and protective milieu, with medical provisions for intercurrent illnesses.
- (2) To counteract marked and ominously expanding psychotic patterns by every effective means, including, as indicated, phenothiazine and other medications or, far less frequently, *dauerschlaf*, "shock" modalities or even cerebral surgery when all other measures fail.
- (3) Concurrently, to establish rapport between the patient and his therapist not by verbal techniques alone, but by utilizing other, possibly more meaningful modes of communication such as behavioral rewards, play activities, music, calisthenics and occupational retraining.
- (4) To permit the development of varieties and intensities of therapeutic relationships with ancillary therapists which are not ordinarily needed (and are usually contraindicated) in the treatment of nonpsychotic states.
- (5) To utilize these initially fragile and deviant therapeutic relationships in a manner best calculated to convert them from psychotic transferences into more mature, stable and realistic forms of interpersonal and group interactions.
- (6) To leaven this process with a degree of warmth and a continuity of active guidance not usually indicated in the therapy of neurotic deviations.
- (7) To employ every social resource of the hospital, clinic and community that might aid in the familial, occupational, esthetic and social rehabilitation of the patient.

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## Appendix A

### GENERAL SUPPLEMENTARY READING

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## Appendix B. Glossary

### CLINICAL DEFINITIONS OF PSYCHIATRIC TERMS

**AFFECT** Generalized feeling tone, usually distinguished from emotion in being more persistent and pervasive, less intensely reflected physiologically and with more generalized ideational content.

**AFFECTIVE PSYCHOSES** Psychoses (q.v.) prominently characterized by marked changes in mood; e.g., depression or mania.

**AKATHISIA** Restless muscular activity, such as may be induced by phenothiazines.

**ALZHEIMER'S DISEASE** A generalized fibrillary degeneration of the cerebral cortex with glial plaque formation occurring in late middle life, and manifested by a variable but usually rapidly progressive symptomatology comprising aphasia, apraxia, intellectual deterioration, habit disintegration, explosiveness of affect, and occasionally, convulsive seizures.

**AMBIVALENCE** Incompatibility of covert motivations with regard to alternative possibilities of action; e.g., mixed love and hate for the same person.

**AMENTIA** Lack of development of intellectual (q.v.) capacities, due to congenital defects.

**AMNESIA** Loss of memory or recall. *Retrograde a.* signifies forgetfulness for events following some *amnestic trauma* such as a cerebral concussion or an epileptic seizure, as distinguished from *anterograde a.* or loss of memory for preceding events. *Lacunar* or *patchy a.* connotes an inability to recall specific events or portions of them, with preserved memory for episodes between them.

**ANACLISIS** Dependent leaning on another.

**ANHEDONIA** Inability to experience pleasure.

**ANIMA** The inner feminine nidus of men (Jung).

**ANIMUS** The inner masculine nidus of women (Jung).

**ANOREXIA NERVOSA** Prolonged neurotic self-starvation; in young women with amenorrhea, sexual frigidity and progressive cachexia.

**ANXIETY** A state of apprehensive tension which arises during adaptational conflicts and insecurities. Anxiety is experienced in circumstances of direct or symbolic danger, or when phobic, compulsive, paranoid or other accustomed adaptations are transgressed. *A.* may stimulate solutions of problems, or rise to *panic*.

**ANXIETY SYNDROME** The physiologic concomitants of anxiety, generally experienced as palpitation (consciousness of racing or pounding heart), shallow, rapid or constricted respiration, *globus* (sensations of tightness or lump in the throat), trembling, "fluttering" in the abdomen, sweaty, flushed or pale skin, and a diffuse apprehensiveness which may mount to feelings of impending catastrophe. Incontinence may occur in severe episodes.

**APHASIA** Impairment of communicative functions. *Sensory* or *impressive a.* includes inability to perceive auditory, tactile or visual speech-symbols; *semantic a.* denotes impaired recall (*amnestic a.*), recognition (*anomia*), or correlation (*syntactic a.*) of speech symbols; *motor* are all present in varying degree in *organic a.* and, when complete, constitute *global a.* In *functional* or *neurotic* (q.v.) *a.* one or several of the above dysfunctions may appear in relative isolation.

**ASSOCIATION, FREE** 1. The psychoanalytic technique of requiring the patient to express or describe all thoughts, sensations and emotions as they occur during the analytic hour. 2. The verbalizations so elicited.

**AURA** Sensations or other prodromal experiences (sometimes hallucinatory) which regularly or irregularly precede each episode of a paroxysmal disorder; e.g., migraine or epilepsy (q.v.).

**AUTOMATISM** Mechanical, repetitious, apparently undirected, symbolic behavior, often without conscious control; seen in fugue states or schizophrenia (q.v.).

**AUTONOMIC NERVOUS SYSTEM** The portion of the nervous system that regulates the glands, circulation and internal organs. Its *parasympathetic* (craniosacral) division is in general anabolic and inhibitory; its *orthosympathetic* (thoraco-lumbar) division is in general catabolic and excitatory, but (a) there are specific exceptions in organ-innervation, and (b) the two divisions are intimately interactive.

**BEHAVIORISM** A system of psychology (J. B. Watson) that studies the conduct of human beings exclusively on the principle of association and professes to exclude consciousness and other subjective and conative considerations as irrelevant epiphenomena. Therapy (J. Wolpe) includes *reciprocal inhibition* (q.v.) and *reconditioning*.

**BESTIALITY** Sexual intercourse with animals.

**BIODYNAMICS** The historical, comparative and experimental study of the genetic, environmental, experiential and therapeutic dynamics which determine the behavior of organisms.

**BULIMIA** Excessive hunger and food intake.

**CASTRATION COMPLEX** In psychoanalytic theory, fear of traumatic degenitalization in either sex as punishment for forbidden erotic desires. The term, however, has been used with a variety of connotations ranging from fear of literal castration (Freud) to symbolic deprivation of any cherished possession.

**CATAPLEXY** A transient attack of muscular weakness with or without loss of consciousness. May occur in conjunction with narcolepsy (q.v.).

**CATASTROPHIC REACTION** Severe disintegration of behavior under excessive stress, especially in patients whose adaptive capacities are impaired by cerebral injury (K. Goldstein).

**CATATONIA** A clinical form of *schizophrenia* (q.v.) characterized by *negativism* (q.v.), motor rigidity, or, rarely, *flexibilitas cerea* (v. text), stupor, occasional marked excitement and an episodic course.

**CATHARSIS** The partial dissipation of the morbid residua of a repressed traumatic experience by therapeutic verbalization or *acting-out*, accompanied by an emotional discharge or *abreaction*. This occurs during psychoanalytic therapy, or it may be induced by hypnosis (*hypnotherapy*) or drugs (*narcoanalysis*) with or without interpretation and guided retraining by the therapist (narcosynthesis)—a form of rapid therapy often effective in acute combat neuroses (Horsley, Grinker).

**CATHEXIS** In psychoanalysis, "libidinal charge," or investment of an object or idea with special significance or value-tone for the individual; e.g., individualized love, hatred, or ambivalent combinations of affect with reference to a thing or person.

**CHARACTER** The interrelated patterns of behavior of an individual; distinguished by some from *personality*, in that the latter may mean more specifically the social manifestations of character patterns.

**COMMUNITY MENTAL HEALTH** Preventive and therapeutic psychiatric programs in collaboration with allied disciplines and social agencies.

**COMPLEX, INFERIORITY** In Adlerian individual psychology, covert feelings of inferiority or inadequacy stemming from excessive disciplinary subordination or physical inadequacies (*organ inferiority*) in childhood, for which the individual may try to overcompensate by

excessive ambitiousness, aggressiveness, domination, or special accomplishment to overcome the handicap.

**COMPLEX, OEDIPUS** In early psychoanalytic theory, the erotic attachment of the child to the parent of the opposite sex, repressed because of the fear of *castration* (q.v.) by the jealous parent. (From the Greek myth in which Laius, King of Thebes, exiles his infant son Oedipus, who is rescued by a shepherd. Later Oedipus in his wanderings [identity seeking] unknowingly castrates himself, renounces his sons and preempts his daughters, but is eventually forgiven and joins the gods. The myth thus transcends Freudian connotations, and epitomizes many human vicissitudes and hopeful solutions.)

**COMPULSION** An act carried out (despite some conscious rejection and resistance by the patient) in accordance with a persistent idea (*obsession*) and in order to avoid inexplicable anxiety should the impulse not be followed.

**CONATION** Covert motivation.

**CONDENSATION** A process by which many concepts may be represented by one. For instance, in symbolic imagery a snake may represent phallic eroticism, slinking danger, low bestiality, pitiless aggressivity, mystic fascination, etc. So, too, a *phobia* or a *conversion* symptom (q.v.) may condense and represent in compromise form many otherwise incompatible symbolizations and adaptations.

**CONDITIONING** In Pavlovian reflexology and Watsonian behaviorism, the process by which innate responses ("unconditioned reflexes"), when associated with new sensory stimuli, may thereafter be evoked by these stimuli.

**CONFABULATION** A tendency to substitute detailed but fantastic, inconsistent and variable accounts—each version currently believed by the patient during its telling—to fill in gaps of memory produced by organic cerebral disease, e.g., as in *alcoholic* (*Korsakoff*) or *senile psychoses*, (qq.v.).

**CONSCIENCE** Conscious inhibitions through covert fear of punishment. See *Guilt*, *Superego*.

**CONVERSION** In psychoanalytic theory, the process whereby sexual libido is "converted" and redirected into bodily (*autoplastic*) aberrations of behavior. The term is now mainly used to designate *hysterical* (q.v.) sensorimotor dysfunctions, such as blindness or paralysis.

**COPROPHILIA (-PHOBIA)** Attraction to (or excessive aversion to) feces or dirt.

**COUNTERTRANSFERENCE** 1. In psychoanalytic theory, the symbolic libidinal relationships, partly unconscious, of the analyst with the analytic patient (*analysand*) which may impair the ideal objectivity of the analytic process. 2. In general, the therapist's attitudes toward the patient, based on the former's interpersonal evaluations of the latter.

**CRETINISM** Congenital physical maldevelopment and mental retardation due to thyroid dysfunction.

**CRIMINALITY** Asocial, antisocial or illegal conduct which is in accord with the conscious standards and intent of the individual. Theoretically, though not always practically, distinguishable (1) from *neurotic* or *sociopathic* behavior (qq.v.), in which the aberrant conduct is definitely symbolic rather than indulged in for extrinsic gain, and (2) from *psychotic* behavior (q.v.), in which excesses of uncontrollable affect or distortions of generally accepted reality occasion the antisocial act.

**CYCLOTHYMIA** A tendency to persistent, irrational or exaggerated shifts in mood, especially with regard to alternations of euphoria (*hypomania, mania*) and depression (*hypothymia, melancholia*).

**DEATH INSTINCT** See *Instinct*.

**DEFENSE MECHANISM** 1. In psychoanalytic theory, a process by which the *Ego* (the orientative and integrative portion of the personality) partially satisfies the unconscious in-

stinctive drives of the *Id* by behavior that conforms with the self-regulative demands of the *Superego* (qq.v.). 2. In general, adaptive modes of behavior constituting compromises among the needs of the organism and its experientially contingent perceptions and evaluations of its milieu.

**DÉJA VU** An illusion of having seen a place or event previously.

**DELINQUENCY** Asocial, antisocial, illegal or culturally nonconforming conduct in a minor.

**DELIRIUM** In modern usage, a state of disorientation and confusion (often with rapidly changing, generally fearful hallucinations) induced by the toxic effects of organic diseases or drugs, (e.g., alcoholic *delirium tremens*).

**DELUSION** A fixed belief widely deviant from the cultural norm, and impervious to persuasion or reason.

**DEMENTIA** Deterioration of perceptive, integrative and responsive (e.g., "intellectual") capacities due to organic disease of the brain.

**DEMENTIA, SCHIZOPHRENIC** A term referring to the supposed "mental degeneration" in schizophrenia (q.v.). However, there is only disinterest in, and abandonment, disuse or distortion of, complex intellectual and social processes, but no demonstrable deterioration of capacities (dementia) occurs unless secondary organic cerebral changes supervene as a result of the patient's physical debility or intercurrent diseases.

**DENIAL** In psychoanalysis, an unconscious defense whereby the patient refuses to recognize or accept unwelcome conations or concepts.

**DEPERSONALIZATION** A subject's feeling or belief that he has lost his identity. *D.* is evanescent in *hypnoagogic states* or in *neurotic* reactions, but may be persistent and accompanied by cosmic delusions in the *psychoses* (qq.v.).

**DEPRESSION** A state characterized affectively by maintained dejection in mood, ideologically by gloomy ruminations or forebodings, and physiologically by the depressive syndrome (q.v.). Depressions range in intensity and persistence from evanescent "blues" to deep melancholia. *See* *Psychoses*, depressive.

**DEPRESSION, REACTIVE** A self-limited state, the content, intensity and duration of which have rational reference to "actual" rather than "symbolic" frustrations, deprivations or adversities in the life of the patient. Distinguished from *psychosis* by the criteria listed under the latter (q.v.).

**DEPRESSION SYNDROME** Typically includes varying degrees of anorexia, loss of weight, constipation or other gastrointestinal dysfunctions, easy fatigability and diminished sexual desire. In women, disturbances of menstruation are common; in men, relative impotence. Energy is generally decreased so that ideation and action are slowed, but diurnal variations (morning retardation, partially dispelled toward evening) may occur. However, there may be episodes of markedly increased appetite (bulimia), or a persistent, aimless, motor restlessness (agitation) may supervene.

**DEREISTIC** Unreal, delusional; i.e., not in accordance with generally accepted interpretations of space, time and logic. Generally applied to schizophrenic or paranoid fantasies and their "irrational" organization.

**DESENSITIZATION** *See* Reciprocal inhibition.

**DETERIORATION** 1. Degeneration of intellectual capacities due to organic cerebral disease (e.g., *alcoholic d.*; *senile d.*), as manifested by various *amnesias*, *aphasias*, *apraxias*, disturbances of category formation and impairment of energy (power factor), or loss of other intellectual functions.

**DIAGNOSIS** Determination of the nature of vital processes and their somatic and behavioral effects. In modern psychiatry, diagnosis entails a balanced survey of the nature, context and extent of all significant aberrations, as distinguished from mere superficial classification by "disease entities" (taxonomic nosology).

**DISPLACEMENT** The transfer of symbolic meaning and value from one object or concept to

another: e.g., a mother may cherish a pet excessively after her child's death; a man may redirect unconscious hate of his father onto his boss; or a girl may conceal displaced concern over genital functions in obsessive-compulsive oral hygiene.

**DISSOCIATION** 1. The severance of normal relationships and sequences among motivations, thoughts and affects. 2. Complex combinations of behavior patterns which, though integrated among themselves, may appear unrelated to the rest of the personality, giving rise to "double" or "*multiple personality*" (Prince) or to "encapsulated paranoia."

**DISTORTION** An adaptive alteration of a perception or concept to conform with the subject's wishes or prejudices; e.g., an aberrant apperception and evaluation of the personality characteristics of a loved or hated person.

**DOWN'S SYNDROME** A genetic defect (trisomy 21) causing physical maldevelopment and intellectual retardation. Formerly *Mongolism*.

**DREAM FUNCTION** In psychoanalytic theory, a process by which dream fantasies express unconscious wishes and reexplore and allay anxieties through symbolic representation and resolution.

**ECONOMICS** 1. In dynamic psychiatry, the study of the respective weighting, interaction and balance of adaptive processes to produce final behavior. 2. In psychoanalytic theory, the distribution of *libido* according either to the pleasure principle, the psychosexual development or the *death instincts* (qq.v.).

**EGO** In psychoanalytic theory, that portion or stratum of the "mind" or personality which is in contact with the environment through the senses, perceives and evaluates the milieu through intellectual functions, and directs behavior into acceptable compromises between the blind drives of the Id and the inhibitions (*conscience*) and idealizations (Ego-ideal) of the Superego (qq.v.).

**EGO ANALYSIS** In psychoanalysis, the investigation of the methods (*defenses*) by which the Ego (a) resolves conflicts among Id drives or between these and excessive Superego inhibitions or goals, thus averting disruptive anxiety, and (b) adapts by "normal" or "neurotic" mechanisms to the demands of reality as conceptually interpreted.

**EGO-IDEAL** In psychoanalytic theory, that portion or function of the Superego which orients and directs the personality toward attainments—usually those of other persons with whom the subject has, in the past, identified his own interests.

**EIDETIC IMAGERY** Vivid, detailed, accurate, voluntarily controllable recall of previous sensory impressions, reported to be present in 60 per cent of children and in some adults (see Types, Jaensch).

**ELECTRO-CONVULSIVE THERAPY** A form of treating psychiatric disorders by passing an electric current through the brain, usually with the induction of convulsions and coma.

**EMOTION** A state of excitation manifested during conative press or conflicts, and reflected in characteristic physiologic reactions and motor expressions (*e-moto*).

**EMPATHY** The "objective" or "intellectual" recognition of the nature and significance of another's behavior, as distinguished from *sympathy*, derived from corresponding conative and affective experiences. See *Rapport*.

**ENCEPHALITIS** Inflammation of the brain.

**ENGRAM** Neural repository of memory.

**EPICRITIC SENSITIVITY** Accurate appreciation of light touch, temperature and point-to-point distance on the skin; distinguished from grosser *protopathic* sensations of pain or pressure (Head).

**EPILEPSY** A group of disorders characterized mainly by motor convulsions and/or disturbances of consciousness, often traceable by electroencephalography to cerebral dysrhythmias; generally episodic, except in the *continuous partial epilepsy* of Wilson and in *status epilepticus*. Distinguished from toxic convulsions and hysterical seizures in etiology, course and prognosis (qq.v.). Cf. Epilepsy, major.

**EPILEPSY, JACKSONIAN** Recurrent convulsive movements beginning in one extremity and accompanied by minimal disturbances of consciousness. These may arise from circumscribed cerebral lesions (Hughlings Jackson).

**EPILEPSY, MAJOR (GRAN MAL)** Episodic disturbances or abolition of consciousness, with tonic contractions rapidly involving the whole body (*opisthotonus*), followed by violent clonic movements, during which there may be urinary or fecal incontinence. The attack may be heralded by a prodromal *aura* (sensory, affective or hallucinatory experiences) and the convulsions may be immediately preceded by an explosive *epileptic cry*. If the patient is not prepared for the seizure he generally falls, and may bite his tongue or injure himself during the convulsions. *Post-dromata* often consist of lassitude, muscular weakness or soreness, headache, and amnesia for the seizure. Epilepsy may be distinguished from toxic convulsive states (e.g., strychnine tetany) and *hysterical seizures* (qq.v.) by its etiology, symptoms and course.

**EPILEPSY, MINOR (PETIT MAL)** Characterized by relatively mild muscular movements, or sometimes only by momentary impairments of consciousness (absences), during which, the patient may automatically continue his previous activity (minor *epileptic fugue*).

**EPILEPTOID PERSONALITY** Thought by some to comprise traits of intense affective ambivalence, obsessive-compulsive tendencies, hypersensitivity, mysticism and religiosity, and propensity for vacillating instability between extremes of impulsive behavior. However, it is highly probable that the concept of an "epileptic character type" has no independent validity, and in the relatively few patients in whom such traits are marked, they represent secondary neurotic reactions to the epileptic disorder rather than a correlated constitutional deviation.

**EPILEPTIC EQUIVALENTS** Any episodic sensory, motor, or experiential phenomena that may replace convulsive seizures in epilepsy (psychic epilepsy).

**EPILEPTIC FUGUE** A state of disturbed, clouded, bewildered or dreamlike consciousness with integrated but automatic and occasionally violent activity following epileptic seizures. The fugue may persist from minutes to (in rare cases) days, and is thereafter generally submerged in almost complete amnesia.

**EPILEPTIC STATUS (STATUS EPILEPTICUS)** Incessant or nearly continuous epileptic seizures which, in extreme cases, may lead to exhaustion and death if not therapeutically controlled.

**EPINOSIC (SECONDARY) GAIN** Advantages derived from an illness or behavior disorder, as distinguished from the essential paranoic determinants and phenomena of the illness itself.

**EXISTENTIALISM** Phenomenologic knowledge of and responsibility for "the self" (Heidegger, Sartre, Camus, et al.).

**EXTINCTION** The disappearance of a *conditioned reflex* (Pavlov) when it is repeatedly elicited without reinforcement by the *unconditioned reflex* (see Conditioning) through the provision of a reward.

**EXTRASENSORY PERCEPTION (ESP)** Information supposedly acquired other than by the five acknowledged sensory routes.

**EXTROVERSION** Interest and participation in the "external" world, as distinguished from *introversion*, or preoccupation with endogenous "self-centered" fantasies and *autistic* behavior (Jung).

**EUPHORIA** Illusory sense of excessive well-being.

**FETISH** A symbolically cherished object.

**FIXATION** 1. The persistence of a definite goal or pattern of behavior. 2. In psychoanalytic theory, the continuation into later life of some *pregenital* (e.g., *oral* or *anal*) phase of interest in, or evaluation of, objects (*libidinal cathexis*, qq.v.).

**FORMICATION** Sensation of crawlings on the skin.

**FUGUE** A state in which the patient's consciousness and behavior, though they may be well in-

tegrated, show an apparent break in continuity with previous patterns. *Epileptic fugues* (q.v.) leave an almost complete *amnesia* for their duration; *hysterical fugues* leave a lacunar and generally penetrable *amnesia* (qq.v.)

**GALVANIC SKIN RESPONSE (GSR)** Decreased dermal resistance to a direct current during emotional excitement.

**GANSER SYNDROME** Pretended insanity.

**GENDER IDENTITY** Cultural adoption of a gender role, as opposed to *genetic sexuality*.

**GENERAL PARESIS (DEMENTIA PARALYTICA)** A behavior disorder, the organic precipitating cause of which is syphilitic infection of the brain; in late cases, a frank psychosis characterized by *dementia*, dysarthria and habit deterioration. Pathognomonic neurologic signs may appear and dominate the clinical picture.

**GESTALT** Holistic integration of perceptions and responses. *See also Psychology, Gestalt.*

**GRANDIOSITY** Delusions of being wealthy, famous, powerful, omniscient, etc.

**GUILT** Dread of loss of love or retributive punishment for impulses or deeds forbidden in earlier experiences.

**HALLUCINATION** An auditory, visual, tactile (*haptic*) or other perception accepted as real by the subject but occasioned by no apparent external sensory stimuli. Hallucinations differ from *hypnagogic* (q.v.) or dream imagery in that no corrective reorientation occurs immediately after the imagery ceases, or on waking, although the rapidly changing, fearful hallucinations of toxic *deliria* may be recalled as unreal after recovery.

**HERMAPHRODITE** Anatomically bisexual.

**HOMEOSTASIS** The tendency of organisms to maintain their metabolic processes in so far as possible within optimal limits for individual and race survival (C. Bernard, W. Cannon).

**HYPNOCATHARSIS** *See Catharsis.*

**HYPNAGOGIC** Semiconscious state, usually preceding sleep.

**HYPNOSIS (HYPNOTISM)** A passive state produced by monotonous, reiterated suggestion of relaxation, sleep and control by the hypnotist, in which the subject shows increased amenability and responsiveness to directions or commands, provided that these do not conflict seriously with the subject's own conscious or covert wishes. "Forgotten" memories may be recalled, and altered states of sensibility, perception or motor function may be induced. Acceptable acts may also be compulsively performed by the subject after the hypnotic trance has been terminated (*post-hypnotic suggestion*), and the patient may profess a directed forgetfulness for his experiences during the trance (*post-hypnotic amnesia*).

**HYSTERIA** 1. A state of neurotic sensorimotor dysfunction, e.g., hysterical blindness, palsy or convulsions. 2. The lay term for great emotional and motor excitation ("hysterics") should not be used in this sense in psychiatric description or diagnosis.

**ID** In psychoanalytic theory, a general term for all unconsciously determined instincts or libidinal strivings (q.v.), constituting the conative "portion" of the psyche.

**IDENTIFICATION** Wishful adoption, mainly unconscious, of the personality characteristics or identity of another individual, generally one possessing advantages which the subject envies and desires.

**IDENTITY CRISIS** Intense doubt as to one's role in life.

**IDIOCY, MORAL (MORAL INSANITY OF PRICHARD)** Almost obsolete terms connoting a serious lack of "moral sense" or "moral development," i.e., the inadequate establishment of social responsibilities and adaptations. Cf. *Criminality, Sociopathy*.

**ILLUSION** Misinterpretation of a sensory percept; usually fleeting or correctable by closer or supplementary examination of the stimulus which induced the illusion.

**IMBECILITY** General intellectual deficiency such that the average intelligence level is between

about one-quarter and one-half normal. Imbeciles nearly always require institutional care.

**INHIBITION** 1. In general, the internal checking or restraint of a conation, affect, thought or act. 2. In psychoanalytic theory, the prevention of Id instincts from reaching conscious recognition and response, because of specific Ego controls directed by the Superego (qq.v.). 3. In Pavlovian reflexology (a) the submergence of a positive or *excitatory conditioned reflex* by a contrary *inhibitory* one, (b) the supposed occurrence of a radiating inhibitory process over the cerebral cortex, controlling the corresponding neural reflex arcs.

**INSANITY** A vague legal term variously connoting inability "to distinguish right from wrong," or a "mental state in which the patient is unable to care for himself or constitutes a danger to others." To be distinguished from the psychiatric concept of psychosis (q.v.).

**INSIGHT** 1. Clinically, the patient's own explanation of his illness, progressively judged "distorted," "incomplete," "good," etc., by the observer in so far as it coincides with his own theoretic formulations. 2. In psychoanalysis, the extent of a patient's true (as opposed to merely professed or verbal) understanding of the origins and unconscious dynamisms of his behavior. 3. In Gestalt psychology, the phenomenon of sudden grasp (*ah-ha! erlebnis*) of a perceptual configuration or of the solution to a problem.

**INSTINCT** 1. A conative psychologic term with variable meaning, but generally connoting an inborn tendency toward certain specific patterns of behavior (e.g., the sex instinct, the exploratory instinct, etc.). 2. In older psychoanalytic theory, a primary tendency toward life and reproduction (*Eros*) or toward destruction, dissolution and death (*Thanatos*).

**INTELLIGENCE** The sum total and degree of development of the organism's capacities to perceive, differentiate, integrate and manipulate its environment (Tolman). Spearman contends that there is an over-all index (*g*) of *general intelligence*, plus factors for perseveration (*p*), fluency (*f*), will (*w*) and speed (*s*). Others divide intelligence into less interdependent capacities: e.g., *abstract i.*, *mechanical i.*, and *social i.* (Thorndike), or various special (statistically determined) vectors of intellectual capacity such as *memory (m)*, *verbal fluency (w)*, *space visualization (s)*, *number facility (n)* and, possibly, other factors of induction, deduction, speed of reaction time, perception, judgment, *closure* (including flexibility) and rate of reversal of ambiguous perceptions (Thurstone). In any case, the ordinary tests (q.v.) of *general intelligence* (e.g., the Stanford-Binet or Kuhlman) indicate only rough averages of these abilities; moreover, they often do not take adequate account of intercurrent conative and affective factors, or of the previous training and experiences of the subject.

**INTELLIGENCE QUOTIENT (I.Q.)** A figure indicating the subject's performance on some test of intelligence (q.v.) in relation to the statistical norm for his age; e.g., a child of 12 (*chronological age*) whose performance totaled the 81/2 year level (*mental age*) on the Stanford-Binet test would have an I.Q. of  $81\frac{1}{2} \div 12$  or 71. *See Intelligence.*

**INTROJECTION** In psychoanalysis, imaginal incorporation or absorption of an object or person.

**INTROVERSION** Preoccupation with self.

**INTUITION** A sudden understanding or conviction not reached by conscious reasoning; usually an integration of stored data and wishes which reach consciousness as an illuminating "insight" or inspiration. The resulting behavior may or may not be adaptive or favorable.

**KORSAKOFF PSYCHOSIS** A toxic psychosis (usually alcoholic) characterized by inflammatory or retrogressive changes in peripheral nerves (polyneuritis), disorientations, amnesia with *confabulation* and intellectual deterioration (*dementia*) (qq.v.).

**LATENCY PERIOD** In psychoanalysis, libidinal quiescence between the oedipal ages of four or five and puberty.

**LIBIDO** 1. In psychoanalytic theory, the energy associated with the instincts of the Id. 2. In a more limited sense (medical and lay) the desire for sexual relationships; sex drive.

LOVE 1. An affect or sentiment evoked by a person (concept or object) that fulfills one's needs or expectations. (This definition is not recommended for domestic consumption.) 2. "Love is the effort of two solitudes to protect and touch and greet each other—Rainer Marie Rilke. *See* Rappoart.

MALINGERING The deliberate simulation of disease; usually, however, by neurotic individuals.

MANIA A syndrome of excessive elation, ideation, distractibility and restless activity. *See* Psychosis, manic.

MANIFEST CONTENT Recalled events in dreams, interpreted psychoanalytically as *latent content*. *See* Dreams

MANNERISM A characteristic expression, gesture or movement. When stereotyped and unconsciously repetitious, but minor, it is termed a *tic*. Such movements may become symbolically bizarre and persistent in schizophrenia (q.v.).

MASCULINE PROTEST Overassertion of virility or dominance in either sex (A. Adler).

MASOCHISM 1. In sexology, erotic pleasure derived from physical pain. 2. In older psychoanalytic theory, the satisfaction of destructive instincts (Thanatos) "turned against the self." 3. in biodynamics, the satisfaction of bodily needs through learned adaptive patterns, certain aspects of which may appear unpleasant or painful to an observer.

MECHANISM 1. In psychoanalytic theory, the interaction among psychic "structures": e.g., the Ego "defends itself" against the Id by the "mechanism" of repression (q.v.). 2. In biodynamics, a process of contingent and total organic adaptation devoid of any implication of isolated patterns.

MELANCHOLIA A severe depressive psychosis (q.v.).  
MENS REA Intent to harm.

MENTAL HYGIENE A term employed (but not coined) by A. Meyer to designate the development of optimal modes of personal and social conduct and the prevention of psychiatric disorders.

MESMERISM "Animal magnetism" of Mesmer; later *hypnosis*.

METAPSYCHOLOGY A behavioral theory that cannot be verified or disproved by observation or reasoning.

MIGRAINE A disorder characterized by recurrent attacks of severe localized or one-sided (hemicranial) headaches, which are often preceded or accompanied by visual disturbances.

MIND 1. A generalized metapsychologic abstraction comprising a person's motivations, affects, intelligence, values, beliefs, etc. 2. Operationally, the phenomena of body in internal (including speech) and external action.

M'NAGHTEN RULE A legal precedent from the murder trial of Daniel M'Naghten (England, 1843) to the effect (a) that any act committed by an idiot, imbecile or lunatic cannot be adjudged a crime, and (b) that such persons cannot be tried and punished by criminal procedure if it can be shown that they were aware neither of the "nature" of their act, nor that it was "wrong." This precedent is incorporated into the criminal law of most of our states.

MORON 1. A mentally defective person, with average intelligence (I.Q.) of 50 (*low grade m.*) to 79 (*high grade m.*) as estimated by standard intelligence tests with a "norm" of about a hundred. 2. A lay or journalistic term incorrectly applied to sexual perverts.

MOURNING A state of grief and sadness over a loss; theoretically distinguished from depression or melancholia (q.v.) by the absence of marked self-recriminations, persistent agitation, a severe depressive syndrome or suicidal impulses. Cf. Psychoses, depressive.

MULTIPLE PERSONALITY One or more disparate roles successively acted out by one individual (Morton Price).

**NARCISSISM** or **NARCISSM** From Narcissus, who, for rejecting the devotion of Echo, was condemned by Nemesis to fall in love with his own reflected image. In psychoanalysis, equivalent to original self-love, or to the *reidentification* with, or fantasied *reincorporation* of, objects or persons given a temporary investiture (*cathexis*) of object-love. The first form is called *primary narcissism*, the rederived form *secondary narcissism*.

**NARCOLEPSY** Recurrent episodes of trancelike or sleep states, occurring with no, or almost no, warning, and persisting from a few seconds to several hours. They may be of neurotic etiology. *See* epileptic equivalents.

**NARCOANALYSIS** *See* Catharsis.

**NARCOSYNTHESIS** A therapeutic procedure in which the patient is given a hypnotic drug (e.g., Pentothal) to alleviate his acute anxiety, permitted to express his repressed memories, affects and conflicts (*cf. Catharsis*) and then guided by the therapist to conative and emotional reintegration, behavioral readjustments and social rehabilitation.

**NEED** A psychophysiologic (metabolic) deficiency or imbalance translated dynamically into behavior (characterized variously as motivated by desires, drives, goals, instincts, wishes, strivings, etc.) intended for the direct or indirect satisfaction of the deficiency.

**NEGATIVISM** Excessive opposition to directives.

**NEOLOGISM** An individually coined, usually incomprehensible word.

**NERVES, NERVOUS, NERVOUS BREAKDOWN, NERVOUS SPELLS, ETC.** Lay euphemisms used vaguely to describe behavior disorders. Such terms should never be used, other than in quotes from the patient, in psychiatric description or diagnosis.

**NEURASTHENIA** A euphemistic term for a vague group of symptoms consisting of muscular weakness or fatigability, inertia, petulant irritability, aversion to effort, variable aches and pains, and minor organic dysfunctions. At present the term has no connotation of organic disease of the nervous system.

**NEUROSES** A group of behavior disorders representing suboptimal adaptations to biodynamic stresses, conflicts or uncertainties. Neuroses are characterized symptomatically by 1. *anxiety*, with its recurrent physiologic manifestations (*see Anxiety syndrome*), more or less covert, or 2. by various sensorimotor (*hysterical*) or organic-neurotic (*psychosomatic*) dysfunctions (qq.v.). Generally, the history reveals previous sensitivities and maladaptations to frustration and conflict, exacerbation of neurotic symptomatology under duress, and partial recovery when stress is relieved either spontaneously or under therapy. For theoretic and practical purposes, neuroses are distinguished from psychoses by the criteria listed under the latter (q.v.), although all forms of transition occur. *See* Chapter 4.

**NEUROSIS, CONVERSION** A neurosis (q.v.) characterized predominantly by dysfunctions of (a) sensation or motility (*hysteria*) or (b) one or more organ-systems (organ neuroses). Frank anxiety or *obsessive-compulsive* features (q.v.) may be minimal, especially when the hysterical symptoms serve as adequate adaptations.

**NEUROSIS, OBSESSIVE-COMPULSIVE** A neurosis characterized prominently by admittedly irrational but persistent thoughts and impulses, usually combined with phobias. When these are resisted or transgressed, an acute *anxiety syndrome* occurs (qq.v.).

**NIRVANA FANTASY** From Buddhist theology, a state in which there is no desire, no affect, and no strife—only pervasive peace. Differs from uterine fantasies (q.v.) in the sense that the latter may connote deeply regressive maternal-cosmic reidentification (q.v.) as well as sublime security.

**OBSESSION** A persistent, conscious desire or idea, recognized as being more or less irrational by the subject, which usually impels compulsive acts on pain of *anxiety* (qq.v.) if they are not performed. Obsessions can often be analyzed as conscious reflections of conflictual wishes.

**OCCUPATIONAL THERAPY** Treatment by diverting the patient's energies into constructive recreational or manual pursuits satisfactory to him.

**OLIGOPHRENIA** Mental retardation (A. Meyer).

**ONANISM** Coitus interruptus.

**ORGASM** The height of erotic pleasure, just preceding detumescence and relaxation. Generally refers to erotic sensations centered in the genitals, but orgasmic sensations in the mouth, breast, anus or even skin (as in masturbatory-equivalent scratching) have been described.

**ORIENTATION** Awareness of place, time, circumstances and interpersonal relationships.

**ORTHOPSYCHIATRY** The comprehensive, interdisciplinary study of the phenomena and dynamisms of the development of "normal" behavior, with emphasis on child and preventive psychiatry and "mental hygiene" (q.v.).

**OVERCOMPENSATION** 1. An adaptive process particularly stressed by Alfred Adler, whereby a person overreacts to initial deficiencies, handicaps or inhibitions in some sphere of activity by becoming exceedingly adept in that field (e.g., Demosthenes, afflicted with an impediment of speech in his youth, strove for, and succeeded in reaching the pinnacles of oratorical power). 2. In psychoanalytic theory, an excessive overplay of any defense mechanism; e.g., revealing overpoliteness toward a disliked person; or compulsive *satyriasis* (q.v.) as a defense against covert homosexual tendencies.

**OVERDETERMINATION** A process whereby a single behavior pattern becomes adaptive to many covert needs, thus rendering it particularly fixed and resistant to therapy. For instance, a *hysterical paralysis* (q.v.) of an arm may be a combat flier's initial reaction to a crash landing, but later the same symptom may also come to symbolize (a) a denial of his own mobilized aggressions, (b) a rationalized excuse for not returning to a hated civilian job, (c) expiation for a regressive dependence on a government pension, etc. In this sense, overdetermination parallels the process of *condensation* (q.v.) in the formation of verbal and dream symbols.

**PANIC** Extreme anxiety, with blind flight or marked disorganization of behavior.

**PARALYSIS AGITANS (PARKINSON'S DISEASE)** An organic disease of the brain, particularly of the basilar nuclei, caused by inflammation (*encephalitis*), drugs or senile changes, and characterized by progressive muscular dystonia, spasticity and tremor, disturbances in motor control (*festination, retropulsion, and akathesia*) and sometimes by outbreaks of irrational rages and excitements.

**PARANOIA** Delusions of grandiosity or persecution. See *Psychoses*.

**PARAPSYCHOLOGY** A system based on postulates of *extrasensory perception* (q.v.).

**PARASYMPATHETIC NERVOUS SYSTEM** The crano-sacral, vagal, cholinergic and

**PARESIS** An organic psychosis (q.v.) caused by syphilis of the brain, and generally characterized by affective instability with recurrent excitements, muscular tremors, speech disturbances, pathognomonic changes in the pupillary reactions and in the spinal fluid, and progressive behavioral deterioration. See also *General paresis*.

**PARESTHESIA** Deviant tactile sensation.

**PAVOR NOCTURNUS** Nightmares or night terrors.

**PEDERASTY** Anal intercourse with children.

**PEDOPHILIA** Sexual attraction to children.

**PERCEPTION** The integration of sensory stimuli to form an image, the configuration and interpretation of which is influenced by past experiences.

**PERSEVERATION** Irrational repetitions of ideas or acts.

**PERSONA** One's external facade, distinguished from his internal *anima* or *animus* (Jung).

**PERSONALITY** Comprises the sum total of the unique behavior patterns of an individual, particularly those concerned in his social relationships (*cf.* Chapter 6).

**PERSUASION** A form of therapeutic influence, usually conceived as verbal, by which the patient's motivations, covert as well as conscious, are directed toward goals desired by the therapist.

**PHENOMENOLOGY** "Reality" as interpreted by the self rather than as an absolute.

**PHENOTYPE** Physical build, as the milieu and individual experiences influence the *genotype*.

**PHOBIA** A morbid aversion to an object, situation or act, generally derived from its symbolic reference to an anxiety-ridden previous experience or series of experiences. Specific designations, derived from Greek roots, for the almost infinite varieties of phobias are rapidly becoming obsolete, but the following is a partial list—arranged by the symbol feared—of many terms still found in the literature: Morbid dread of activity, *ergasiophobia*; of air, *aerophobia*; of animals, *zoophobia*; of apparitions, *phasmophobia*; of bees, *mellisophobia*; of birds, *ornithophobia*; of burial, *taphephobia*; of cats, *ailurophobia*, *galeophobia*, or *gatophobia*; of childbirth, *maieusiphobia*; of choking, *pnigophobia*; of climbing, *climacophobia*; of coitus, *cpriphobia*; of cold, *psychrophobia*; of color, *chromatophobia*; of constricted spaces, *claustrophobia*; of crossing water, *gephryophobia*; of crowds, *oclophobia*; of dampness, *hydrophobia*; of darkness or night, *nyctophobia*; of dawn, *esophobia*; of death, *thanatophobia*; of dead bodies, *necrophobia*; of deformity, *dysmorphobia*; of depths, *bathophobia*; of dirt, *myophobia*; of disease, *pathophobia*, *nosophobia*; of dogs, *cynophobia*; of drugs, *pharmacophobia*; of eating, *sitophobia*; of everything, *panaphobia*; of evil spirits, *satanophobia*; of excreta, *coprophobia*; of contamination by excrement, *scatophobia*; of exhaustion, *kopophobia*; of fear, *phobophobia*; of female genitalia, *eurotophobia*; of fire, *pyrophobia*; of fish, *ichtyophobia*; of food, *cibophobia*; of gait, *cherophobia*; of heat, *thermophobia*; of heights, *acrophobia*; of hell, *hadephobia*, *stygiophobia*; of infestation, *parasitophobia*; of injury, *traumatophobia*; of becoming insane, *lyssophobia*; of insanity, *maniaphobia*; of irresponsibility, *paralipophobia*; of lightning, *keraunophobia*; of loneliness, *ere-miphobia*; of marriage, *gamaphobia*; of materialism, *hyclophobia*; of micro-organisms, *bacillophobia*; of mirrors, *eisoptrophobia*; of giving birth to a monster, *teratophobia*; of movement, *kinesphobia*; of nakedness, *gymnophobia*; of names, *onomatophobia*; of Negroes, *negrophobia*; of anything new, *neophobia*; of odors, *olfactophobia*; of overworking, *ponophobia*; of pain, *algophobia*; of parasites, *parasitophobia*; of pleasure, *hedonophobia*; of pointed objects, *aichomophobia*; of poison, *iophobia*; of poverty, *peniaphobia*; of projectiles, *ballistophobia*; of punishment, *mastigophobia*; of red, *erythrophobia*; of responsibility, *hyphenyophobia*; of right, *dextrophobia*; of seas, *thalassophobia*; of sermons, *homilophobia*, *eniosphobia*; of sitting, *thaassophobia*; of small inanimate objects, *acarophobia*; of snakes, *ophidiophobia*; of solitary places, *agoraphobia*; of sounds, *acousticophobia*; of (empty) spaces, *cenophobia*; of specific place, *topophobia*; of spirits, *daemonophobia*; of stealing, *kleptophobia*; of storms, *brontophobia*; of strangers, *xenophobia*; of sunlight, *heliophobia*; of talking or stuttering, *laliophobia*; of thunder, *tonitrophobia*; of being touched, *haptophobia*; of touching, *aphophobia*; of transgressing, *peccatiphobia*; of trembling, *tremophobia*; of tuberculosis, *tuberculophobia*, *phthisophobia*; of vehicles, *amaxophobia*; of virgins, *parthenophobia*; of vocal sounds, *phonophobia*; of vomiting, *emetophobia*; of water, *hydrophobia*; of being weak, *asthenophobia*; of women, *gynephobia*; of writing, *graphophobia*.

**PHRENOLOGY** Correlation of personality traits with conformation of the skull (F. Gall). A concept now discarded.

**PICA** Perversion of the appetite; toxic feeding.

**PLACEBO** Object or maneuver used solely to placate another.

**PLEASURE PRINCIPLE** In psychoanalytic theory, the seeking of release from libidinal ten-

sions (giving pleasure) as distinguished from various manifestations of the death-instinct or Thanatos (such as in the *repetition compulsion* or *masochism*, q.v.).

PRECONSCIOUS Recallable concepts.

PREJUDICE An intellectual set which covertly biases or distorts a subject's apperception and evaluation of later experiences according to his predetermined attitudes.

PREVENTION IN PSYCHIATRY *Primary*: to forestall behavior disorders genetically or environmentally. *Secondary*: To limit their occurrence. *Tertiary*: To treat them. Obviously, these "preventive" rubrics overlap.

PRIVILEGED COMMUNICATION Information that ethically cannot be revealed by a physician.

PRIMARY PROCESS In psychoanalysis, instinctive, unreasoned conations, thoughts or actions. *See* *Id*.

PROJECTION An unconscious defense process whereby the subject attributes his own motivations, concepts or acts to others.

PROLONGED SLEEP Treatment of behavior disorders by continuous sleep (1 to 20 days) induced by drugs such as paraldehyde or Amytal (*Dauerschlaf*).

PSYCHOANALYSIS A psychologic system of research, theory and therapy, the broad outlines of which were propounded by Sigmund Freud (1856-1939). Cf. index and references for the multiple elaborations and applications of this theory.

PSYCHOBIOLOGY An eclectic system of behavior research, theory and therapy outlined by Adolf Meyer (1866-1944). *See* Reaction Types and index.

PSYCHODRAMA Group therapy in which patients or therapists act out roles relevant to each others' lives (J. Moreno).

PSYCHOLOGY, GESTALT A psychological system (Wertheimer, Koffka, Kohler, et al.) which rejects elemental stimulus-response (*reflex*) concepts, stresses the indivisible wholeness of perceptual configurations (*Gestalten*), and emphasizes the sudden "insightful" nature of learning as opposed to trial-and-error or automatic "association."

PSYCHONEUROSIS A term now generally used as equivalent to *neurosis* (q.v.) or sometimes as implying severe neuroses with larval or minimal psychotic tendencies or admixtures.

PSYCHOPHYSIOLOGIC DISORDERS *See* Chapter 7.

PSYCHOSES A group of grave disorders of behavior, most of which satisfy the legal criteria of "insanity" in that the patient is unable to care for himself and/or constitutes a danger to others. Psychoses, however, also fulfill one or more of the following psychiatric criteria: (1) Loss of contact with, or marked distortion of socially accepted interpretations of reality (as shown in deviated perceptions, thinking disorders, *hallucinations* or *delusions*). (2) Severe and persistent disorders of *affect* (e.g., manic *euphoria*, depressive *melancholia* or *schizophrenic regression*, with (a) retreat from, or perversion of, social relationships (e.g., perverse passivity, dependency or aggressivity), or (b) habit reverisons (e.g., open masturbation, soiling, etc.). (4) Personality disintegration, so that elementary erotic and hostile impulses or *automatisms* are released from control. (5) (a) Acute derangement of perceptive-interpretative-manipulative (*intellectual*) capacities (as in toxic *deliria*), or (b) the permanent deterioration of such capacities (as in psychoses with organic cerebral disease).

PSYCHOSES, DEPRESSIVE Variously characterized by melancholic fixation of mood, retardation of apperception and response, self-depreciatory preoccupations (ideas of inadequacy, of guilt and of being hated), morbid preoccupation with anticipated punishment, nihilism and regression, suicidal tendencies, and a marked depressive *physiologic syndrome* (q.v.) comprising insomnia, anorexia, loss of weight, sexual disturbances and various organic (especially gastrointestinal) dysfunctions

**PSYCHOSES, INVOLUNTARY** Originally considered to be a definite syndrome characterized mainly by melancholia and agitation, generally progressing to hebetude and intellectual deterioration. Actually, psychoses occurring in the involuntory period vary widely in etiology, clinical expression and prognosis (see Chapters 7 and 8).

**PSYCHOSES, MANIC** Characterized by extreme emotional lability (though with superficially euphoric affect), psychomotor hyperactivity (uninhibited flow of free-associative speech and conduct), hypersensitivity to stimuli with marked distractibility, and a tendency to unorganized delusions of grandiosity. Manic episodes are generally self-limited in duration; occasionally, they are apt to recur regularly (*cyclic mania*) or in alternation with periods of depression (*manic-depressive psychosis*). Rare cases of *chronic mania* (Schott) have been reported.

**PSYCHOSES, ORGANIC** Severe disorders of behavior in which pathologic changes in the body, especially in the central nervous system, are etiologically significant contributory factors; e.g., psychoses with pellagra, chronic alcoholism, cerebral tumor, brain syphilis, etc. Organic psychoses are characterized by dementia and, generally, by impaired affective control.

**PSYCHOSES, PARANOIAC** Relatively rare (about 4 per cent incidence) and characterized by well-systematized, slowly progressive delusions of influence, reference or persecution which, although based on false premises and interpretations, are relatively logical and consistent, and accompanied by appropriate affect. Paranoia is distinguished from the *affective psychoses* and from *schizophrenia* by minimal affective distortion or personality disintegration; e.g., the paranoiac system is relatively isolated from the rest of the personality pattern (see *Schizophrenia, paranoid*).

**PSYCHOSES, SENILE** Caused by senile degenerative or arteriosclerotic changes in the brain, and generally characterized by progressive dementia (aphasic defects, amnesia for recent events), habit deteriorations (e.g., loss of cultural interests, garrulity, hoarding, personal uncleanliness) and regressions to puerile affectivity (e.g., the petulant dependence and selfishness of "second childhood"). See *Pick's* and *Alzheimer's* disease.

**PSYCHOSOMATIC MEDICINE** The study, theory and application of the dynamics of total behavior (biodynamics) in relation to the practice of medicine and its several specialties.

**PSYCHOTHERAPY** The science and art of influencing behavior so as to make it (a) more efficient and satisfactory to the individual and (b) more compatible with social norms.

**RAPPORT** Empathy and trust between individuals; in psychiatry, between patient and therapist.

**RATIONALIZATION** The conscious justification (usually on grounds of "reason," "logic" or social expediency) of attitudes, concepts and acts after these have already been determined by covert or conscious motivations.

**REACTION FORMATION** In psychoanalytic theory, the process whereby conscious wishes, affects, ideations or modes of conduct are made defensively contrary to rejected impulses; e.g., a father's overtly reactive cruelty to a daughter to whom he is incestuously attracted.

**REACTION TYPE** In *psychobiology* (A. Meyer), the predominant behavior pattern or *ergasia* of a psychiatric patient: i.e., *anergasia* (intellectually defective), *dysergasia* (toxic), *parergasia* (organic), *holergasia* (psychotic), *merergasia* (neurotic part-reaction), *oligergasia* (retarded), *parergasia* (schizophrenic) and *thymergasia* (affective psychoses).

**REALITY PRINCIPLE** In psychoanalytic theory, the modification of the expression of unconscious libidinal drives (*pleasure principle, Eros*) or of the death instincts (*Thanatos* or the *Nirvana principle*) by rational consideration of the requirements of "reality."

**RECIPROCAL INHIBITION** In behavior therapy (J. Wolpe), the mitigation of aversions by increasingly pleasant reassociations.

REFERENCE, DELUSION OF A fixed, irrational belief that one is the object of the thoughts and actions of others.

REFLEX In neurophysiology, a sensorimotor neural pathway. Cf. Conditioning and the Index for other connotations of the term.

REGRESSION 1. The resumption, under stress, of earlier and experientially more satisfactory modes of behavior. 2. In psychoanalytic theory, the return to infantile phases of libidinal organization; i.e., *narcissistic, oral or anal* (qq.v.).

REM SLEEP Dreaming sleep accompanied by rapid eye movements; occurs about a fifth of total sleep time.

REPETITION COMPULSION Drive to reenact traumatic experiences (Freud).

REPRESSION The automatic and unconsciously defensive process of banishing dangerous desires, affects or ideas, singly or together, from awareness; distinguished from suppression, in which the control exercised is seemingly deliberate and conscious.

RESISTANCE In psychiatric, and especially psychoanalytic, therapy, the reluctance of the patient to relinquish accustomed patterns of thinking, feeling and acting, however neurotic, in favor of new and untried modes of adaptation. In psychoanalytic theory, resistance often has the more limited meaning of the Ego's refusal to accept insight into the Unconscious, as shown by the patient's covert rejection of interpretation or the development of a *negative transference* (qq.v.).

SATYRIASIS Exaggerated, diffuse sexual activity in a male.

SCHIZOPHRENIA A group of variable psychotic (q.v.) syndromes characterized predominantly by: 1. General blunting and distortion of *affect*, especially in relation to professed ideational content and interpersonal relationships. 2. Bizarre perceptual and category formations and thinking disturbances, loosely organized into fantastic *delusional systems*, and sometimes projected as *hallucinatory experiences*. 3. Regression to primitive forms of *narcissistic*, *erotic* or *aggressive expression*. 4. Disintegration of behavior with the appearance of *stereotypes* and motor *automatisms* (qq.v.). For the various clinical forms of schizophrenia, see Chapter 8 and below.

SCHIZOPHRENIA, CATATONIC Characterized by motor disturbances (*catalepsy*, *flexibilitas cerea*, *negativism*, mannerisms), stupors or acute outbreaks of hallucinatory excitement, and occasional periods of remission.

SCHIZOPHRENIA, HEBEPHRENIC A highly variable form characterized by early onset, insidious distortion and blunting of affect, inconstant *hallucinosis* and fragmentary *delusional formations*, the development of symbolic mannerisms and *stereotypes*, and progressive deterioration of personal and social habits (Kahlbaum, Kraepelin).

SCHIZOPHRENIA, LATENT Schizoid or schizophrenic tendencies likely to find overt expression under unfavorable stress.

SCHIZOPHRENIA, PARANOID A form in which delusions of *reference* and influence are prominent; distinguished from *paranoia* in that (a) the delusions are highly fantastic, logically bizarre and poorly systematized, and (b) other schizophrenic criteria (affect distortion, pervasive behavioral disintegration, etc.) are also present. See *Psychoses, paranoiac*.

SCHIZOPHRENIA, PROCESS A term sometimes used to designate schizophrenic "etiologic factors".

SCHIZOPHRENIA, PSEUDONEUROTIC Ambulatory schizophrenia underlying severe hysterical, somatic, obsessive-compulsive-phobic, or character neuroses (P. Hoch, S. Rado).

SCHIZOPHRENIC DETERIORATION Disintegration of habit patterns and disuse of intellectual capacities consequent on schizophrenic contraction of interests and deviations or in-perversions of behavior; however, except in so-called *process* (organic) schizophrenia, there is no demonstrable loss of basic abilities.

SCREEN-MEMORY 1. A relatively acceptable memory recalled in place of one charged (*cathected*) with greater anxiety. 2. A retrospective illusion.

SECONDARY GAINS Incidental (*epiposic*) advantages of a neurosis.

SECONDARY PROCESS Rationally adaptive (*Ego-syntonic*) as opposed to unreasoned instinctive (*Id*) thought and conduct.

SHOCK-TREATMENT The subjection of psychiatric patients to convulsive doses of Metrazol, carbon dioxide, insulin or Indoklon, or to an electric current passed through the brain.

SOCIOPATH: SOCIOPATHIC PERSONALITY Generally refers to an individual who is not readily classifiable as predominantly intellectually defective, autoplastically (q.v.) neurotic, or definitely psychotic (qq.v.), but whose behavior is characterized by episodic impulsivity, irresponsibility, lack of emotional control, and inadequate or unstable educational, marital, occupational and other social adaptations. Sociopaths are prone to come into conflict with police or other social authorities—a tendency used by some to distinguish them from a group of "neurotic characters" who keep their eccentricities and aberrations (e.g., extreme prejudices, excessive religiosity, obsessive-compulsive-phobic behavior, etc.) within the bounds of law and custom. Formerly *psychopathic personality*.

SODOMY Anal intercourse.

STEREOTYPY Repetitiousness in speech or action.

SUBLIMATION A "normal" process of directing unconscious and essentially selfish motivations into socially acceptable services or creative activities.

SUBSTITUTION The replacement of conations, affects, concepts or acts by others with a lesser charge of anxiety.

SUGGESTION A process of gestural or verbal communication by which one person may use another's evaluations of him (*transference* relations, q.v.) to channelize the latter's behavior into desired patterns.

SUPEREGO In psychoanalytic theory, that portion or function of the psyche which (a) as *conscience*, prohibits the Ego from direct forms of instinct-expression and thereby prompts the individual to utilize various *defense mechanisms* against unconscious Id impulses, and (b) as Ego-ideal, channels behavior along patterns similar to those of other individuals with whom the subject wishes to identify (i.e., whose advantages he covertly or consciously desires).

SUPPRESSION The deliberate subjugation and control of impulses, ideas, affects and acts felt to be dangerous.

SURROGATE One person placed in another's role.

SYMBOL The more or less remotely displaced representation of an experience in imagery.

SYMBIOSIS An intense, mutually advantageous relationship between or among organisms.

SYMPATHETIC NERVOUS SYSTEM That portion of the nervous system that innervates the organs and glands of the body, as distinguished from the peripheral nerves which innervate the muscles and sense organs. The SNS is usually divided functionally into the *orthosympathetic NS* (generally catabolic) and the *parasympathetic NS* (generally anabolic) (qq.v.).

T-GROUPS Unstructured communication to establish "self-realization" and empathy among small assemblages of individuals for purposes of training (T) or "sensitivity."

TEST Any controlled or standardized situation for investigating the behavior patterns of a subject. Tests frequently referred to in the literature are here grouped as to the field of behavior tested:

TESTS, INTELLIGENCE (q.v.) *Cattell Infant Intelligence Scale*. Performance levels for infants from 2 to 30 months of age. Scored like the Stanford-Binet (q.v.). *Kuhlman Intelligence Test*. Stresses performance over verbal facility and is therefore more accurate in the presence of language difficulties than in the Stanford-Binet (q.v.). Measures also rate of development

(P.A.), speed and accuracy. *Otis Self-Administering*. Four alternate forms for rough estimate of average perceptive-integrative capacity, especially as to speed and alertness. *Stanford-Binet* (revised). Test items are arranged in year levels from two to superior adult. The level at which the subject passes all items is the basal year; his total score is his *mental age*; this divided by his chronological age (up to 16) is his *intelligence quotient* (I.Q.). Tests results are relatively accurate for middle-class children, but not as reliable for adults unless even more contingently interpreted. The "normal" range is from 90 to 109; other ranges are: 0-24, idiot; 25-49, imbecile (both requiring custodial care); 50-69, moron, requiring special extramural supervision; 70-79, borderline; 80-89, dull, normal; 110-124, superior; 135-139, very superior; 140 maximal. Irregularity in performance and failures in abstract items may indicate organic deterioration. *Wechsler-Bellevue Intelligence Scale*. A verbal and performance test standardized on adults, which investigates information, comprehension, arithmetical reasoning, digit memory, similarities, configurational grasp, visual completion and object assembly; or, as an alternate test, the subject's vocabulary. Subtests are weighted for speed and accuracy, and differentially graded. I.Q. as in estimating average intelligence in adults.

**TESTS, PROJECTIVE** These study the subject's "projected" imagery, static or kinetic, in response to standard stimuli. The most frequently used are these: *Rorschach Psychodiagnostic*. The subject describes what he sees in a series of 10 standard cards showing large, almost symmetrical ink-blots, 5 black-and-white and 5 colored. His answers are graded as to form (F), movement (M), color (C) and other criteria as to *whole-field perception* (W), detail organization (D or d), "color shock," chiaroscuro effects (K), banal (P) or original (O) content, etc. Scoring indicates personality patterns (e.g., "pedantry"), special interests and (less reliably) general intelligence. In addition, the patient's performance may reveal deviations of affect, and neurotic or psychotic tendencies. The administration and evaluation of the Rorschach test requires special training and skill, else its reported results may be seriously misleading. *Szondi Test*. The subject's expressed preferences among a series of photographs is held to be psychiatrically diagnostic; highly dubious rationale and reliability. *Thematic Apperception Test*. The subject is shown 20 photographs of various dramatic scenes and is asked to tell a story about each. These stories may then be analyzed as to (1) their themes of opposed motivations and frustrations (Morgan and Murray), or (2) (a) their symbolic significance as to the subject's adaptational conflicts and (b) their verbal content of various expressions, words, or phrases indicating underlying anxiety, doubt or depression, as opposed to wishfully defensive fantasy patterns (Masserman and Balken). The evaluation of this test, too, requires psychiatric training and special experience on the part of the examiner.

**THERAPY** In psychiatry, the science, techniques and art of exerting a favorable influence on behavior disorders by every ethical means available.

**TRANSACTIONAL ANALYSIS** Clarification of personal interactions in terms of "child," "parent" and "adult," with analysis of individual "scripts," maneuvers for advantage, etc (E. Berne).

**TRANSFERENCE** 1. In general, the attribution (transfer) of desires, feelings and relationships, originally experienced by the subject with regard to his parents and siblings, onto other persons who, in the subject's residual attitudes, are assigned parental or other familial roles in his later life. 2. More specifically in psychoanalysis the unconscious attitude of the patient toward the analyst and the role in which the latter is fantasized, e.g., maternal, rivalrous, submissive, erotic, etc.

**TRANSSEXUALISM** A desire to be changed physically to the opposite sex and to act accordingly.

**TRANSVESTISM** Pleasure in dressing as the opposite sex.

**TRIAGE** In clinical psychiatry, the rapid diagnosis and therapy of acute behavior disorders in crisis situations.

**TYPES OF CHARACTER, PERSONALITY OR PHYSIQUE** The various classifications are legion, but the following are most often referred to in the literature:

*Draper, G.*: The hereditary characteristics of an individual (*biotype* as derived from *genotype*), further modified by environment (*phenotype*).

*Galenic-Hippocratic* (humoral). CHOLERIC (dominated by "yellow bile"): mercurial, irritable, impulsive. MELANCHOLIC (dominated by "black bile"): brooding, emotional, depressive. PHLEGMATIC (dominated by "phlegm"): slow, apathetic, stolid. SANGUINE (dominated by "strong blood"): impulsive, active, optimistic.

*Hippocratic*. HABITUS APOPLECTICUS Thick-set, heavy body-build, susceptible to apoplexy. HABITUS PHTHISISICUS Tall, slender, angular body-build susceptible to pulmonary disease.

*Jaensch, W. B.* BASEDOW, or integrated constitution, characterized by a capacity for voluntary control of *eidetic imagery* (q.v.), a tendency to hyperthyroidism, relatively stable emotional organization and a typical digital end-capillary structure. T, TETANIC or uninintegrated constitution, distinguished by lesser control of imagery, low blood calcium, hypersensitivity to stimuli and dissociated personality reactions. Recent work indicates that the Jaensch typology, especially that concerned with its racial implications, has very little scientific validity.

*Jung, C.* INTROVERTED Self-concerned, ruminative, remote, imaginative, inclined to schizoid behavior. EXTRAVERTED Objective, sensitive to external affairs, emotionally labile, active, energetic; inclined to manic-depressive disorders. Jung also speaks of: FEELING TYPES, with labile and sensitive affect, and INTUITIVE TYPES markedly influenced by their unconscious racial and personal heritage.

*Kretschmer, E.* ASTHENIC OR LEPTOSOMIC Characterized by leanness, underweight, flat chest and underdeveloped muscular system, especially marked in the *phthisoid* subgroup. ATHLETIC Characterized by robust musculo-skeletal development. DYSPLASTIC A group of "body-types" which show wide anthropometric deviations from the other three types, and which tend to *schizothymia*. PYKNIC Short, stocky, large body cavities, bradycephalic; inclined to *cyclothymia*.

*Sheldon, W.* ECTOMORPHIC Characterized by predominant development of the ectoderm (epidermis, sense organs and central nervous system), hence sensitive and hyperreactive. ENDOMORPHIC Predominant endoderm derivatives (mainly gastrointestinal organic), hence interest in nutritive living. MESOMORPHIC Predominantly skeletal and muscular, hence active and energetic. All persons are classified as a mixture of these fundamental "types," graded as to predominance on a scale of 1 to 7.

*Stockard, C. R.* "LATERAL" as distinguished from "LINEAR" body types.

*Viola, G.* MICROSPLANCHNIC A "body-type" with small viscera and well developed soma, as distinguished from MACROSPLANCHNIC, corresponding to the *pyknic* (cf. Kretschmer). NORMOSPLANCHNIC OR EUMORPHIC designates a normal intermediate or optimal "body-type."

**UNCONSCIOUS** 1. In general, any behavioral process of which the subject is not directly aware. In addition, *unconscious* has many meanings as variously used in the literature, ranging from stuporous to vaguely mystic connotations of atavistic communalism (Jung, Miller). 2. In psychoanalytic topography, that portion of the *psyche* which comprises the Id instincts, plus those large parts of the Ego (adaptive) and Superego (self-directive) portions of the personality which are in contact with the Id, and the functions of which are not available to direct awareness (*consciousness*) or immediate recall and introspection (*pre-conscious*).

**UNDOING** A defensive reversal of an anxiety-ridden act.

**UR-DEFENSES (-DELUSIONS, -ILLUSIONS)**. Irrational but indestructible faiths in one's own (1) physical powers, (2) supposed friends and (3) magical concepts and practices.

VOYEURISM Excessive pleasure in seeing the opposite sex partially or wholly nude.

WORKING-THROUGH 1. In general, an active re-exploration of a problem situation until satisfactory solutions or adaptations are found and firmly established. (2) In psychoanalysis, the tracing of a symbolism to its "deepest" unconscious sources.

ZEIGARNIK PHENOMENON The drive to complete an unfinished task (B. Zeigarnik, 1927).

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Thanks are due to my secretary, Miss Savilla M. Laird, for invaluable aid in preparing these indices.—*J. H. M.*



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